Cognitive-behaviour therapy for psychosis : individual accounts of the therapeutic process in successful and less successful outcomes

Thesis

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John F. McGowan B.A. (Hons), Ph.D.

COGNITIVE-BEHAVIOURAL THERAPY FOR PSYCHOSIS: INDIVIDUAL ACCOUNTS OF THE THERAPEUTIC PROCESS IN SUCCESSFUL AND LESS SUCCESSFUL OUTCOMES

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COGNITIVE-BEHAVIOURAL THERAPY FOR PSYCHOSIS: INDIVIDUAL ACCOUNTS OF THE THERAPEUTIC PROCESS IN SUCCESSFUL AND LESS SUCCESSFUL OUTCOMES by J. F. McGowan

Abstract

Despite a historical pessimism about the possibility of helping people with schizophrenia using psychological therapies, a great deal of progress has been made recently using cognitive-behavioural therapy (CBT) approaches. These treatments have been developed from changing understandings of schizophrenia, and focus on reducing the distress of psychotic symptoms through coping strategies and altering distressing beliefs. There is increasing evidence that suggests CBT may be helpful for a significant portion of people with psychosis. Limited information on the factors implicated in differing outcomes is available. The present study investigated factors differentiating individuals with good and poor outcomes on the basis of accounts of CBT for psychosis from eight therapist/client dyads.

Four therapists and eight of their clients (two associated with each therapist) were interviewed about their experiences of CBT. Topics covered included, effect of the therapy, elements felt to be helpful and the therapeutic relationship. Interview data was analysed using a qualitative, "grounded theory", methodology.

The analysis produced a number of major categories which differentiated clients who progressed and did not progress in CBT. These included ability to let go of distressing beliefs, logical thought, holding therapy, and presence of a shared goal. Overall, clients who progressed were better able to understand, hold and engage with ideas put forward by the therapist. Additionally, clients' views of CBT were positive and therapists and clients felt that non-specific benefits accrued from the therapy even when CBT specific progress did not occur.

The results were consistent with previous studies suggesting that ability to consider disengaging from distressing beliefs are important in therapeutic progression. However further research is required to clarify the role of logical thought, holding therapy and therapeutic alliance in progress and in predicting outcome. Reasons considered for the inability to progress include, emotional investment in psychotic beliefs and information processing factors.

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Introduction

Psychological Therapies with Schizophrenia

"...it is a waste of time to argue with a paranoid patient about his delusions". Slater and Roth (1969), p. 326.

The quote above, from what was for many years a standard textbook of psychiatry, exemplifies a view which appears to have been widely held in the mental health professions: that conditions classified as "schizophrenia" or "psychotic" disorders are not amenable to verbal modes of treatment. The following literature review considers some of the reasons for this stance and some contradictory evidence from early trials employing cognitive behavioural techniques. The review then goes on to consider recent changes in understanding schizophrenia which have helped foster a growth in cognitive behavioural treatments. These treatments and the evidence for them are then discussed. The final stage of the review concentrates on some of the reasons why these techniques may be effective for some people suffering from schizophrenia but not for others, and introduces the central questions of this investigation into the factors which may be implicated in good and poor outcomes in these kinds of therapies.

Before proceeding, however, it is necessary to define the terms "schizophrenia" and "psychotic" as they will be employed in these discussions. DSM-IV (American Psychiatric Association, 1994) describes schizophrenia as a disturbance usually involving at least two of the following: delusions, hallucinations, disorganised speech, grossly disorganised or catatonic behaviour (all of which are so called positive symptoms), and negative symptoms such as flat affect. Bizarre delusions or particular kinds of auditory hallucinations alone

are also considered sufficient for such a diagnosis. These characteristic symptoms are generally accompanied by social interaction deficits and must have a duration of six months. The working definition of schizophrenia used in this report conforms to that offered by DSM-IV. Reference will also be made to psychotic symptoms which are defined for our purposes as the symptoms of a schizophrenic diagnosis. Reasons for utilising the terms psychotic or psychosis rather than schizophrenia are discussed in the following section (p. 6).

It is difficult to assess the extent to which, at present, the perception that working with schizophrenia using psychological therapies is generally perceived as possible or not. It is clear, however, that psychological treatments have not been commonplace in the past. Some of the reasons for this have been considered by Bentall (1996), who argued that prevailing biological explanations for "schizophrenic illness" have been naturally allied to a pharmacological approach to "cure". This model has been reinforced by a widespread perception of the efficacy of neuroleptic (anti-psychotic) medication prescribed for these types of difficulties. Such a perception is, according to Bentall, often misplaced in view of limited success rates and side effects.

It is clear that estimates of the success of anti-psychotic drugs in relieving schizophrenic symptoms vary somewhat. Considerations of the literature produce estimates of between 5 and 50 percent of people treated as having medication resistant symptoms (see Garety, Fowler and Kuipers, 2000; Jones, Cormac, Mota and Campbell, 2000). It has been argued by Warner (1994) that these drugs have little impact on overall outcome, as many people

with a good prognosis are treated unnecessarily and that long-term treatment followed by withdrawal of drugs may actually cause a worsening of symptomatology. The issue of side effects is also a pertinent one with the list of side effects of such drugs including Parkinsonian symptoms (such as tremor), dystonia (abnormal face and body movements), restlessness and tardive dyskinesia (involuntary muscle movements). (British Medical Association, 1999).

As well as the emphasis on the biological roots of schizophrenia, Bentall (1996) and Fowler, Garety and Kuipers (1995) have argued that a further reason for the pessimism surrounding psychological approaches has been a comparative failure of psychological therapies, and in particular psychodynamic therapies to make a significant impact in this area. This applies to both explanations of schizophrenic symptoms, where psychoanalytic formulations have been largely superseded by biological ones, and also to treatments which broadly do not appear to have been effective. For example, Mueser and Berenbaum (1990) conclude their review of this area expressing the desire to relegate psychoanalytic treatments "to the dustbin of history" (p. 260). It should be noted that this kind of pessimistic conclusion continues to be disputed by authors such as Karon and Vanderboss (1994).

However, the limited success of psychodynamic approaches to date by no means rules out psychologically based approaches as an option for people with schizophrenic symptoms. There have been a number of behaviourally based approaches (see Slade and Haddock, 1996, for a review) using operant conditioning (e.g. reinforcing different interpretations of

voices), systematic desensitisation, aversion therapy and self-instructional training and distraction. Though Slade and Haddock highlighted some of the successes of such approaches, they also pointed out that the generalisation of symptom reduction from the experimental situation to the real world has often been poor.

The psychology literature since the 1950s also suggests that *cognitive*-behavioural approaches might offer an effective way of reducing the distress associated with schizophrenic symptoms. Though the main focus of this chapter is developments in cognitive-behaviour therapy (CBT) for such symptoms since the late 1980s, such approaches are usually traced back to the early work of Beck (1952). In this case study Beck described a successful treatment of a man suffering from delusions. However, though Beck did report an instance of a challenge to the rationality of the man's delusional beliefs, the therapy he described does appear to have been based to a far greater degree on psychodynamic style interpretation than traditional CBT techniques.

A clearer illustration of a CBT style approach was described by Watts, Powell and Austin (1973) in a case series analysis which targeted the modification of distressing paranoid beliefs. Specifically these authors considered how to challenge individuals' distressing beliefs (e.g. about the persecutory intent of others). The primary concern in this study was to minimise "psychological reactance" (p. 259), that is, an increase in resistance from people when their belief is challenged. To this end the authors employed the strategies of initially targeting weaker beliefs, avoiding direct confrontation (via concentrating on the evidence rather than on the belief itself), and encouraging their participants to voice the

alternatives (rather than the therapists putting the alternatives to them). These procedures produced substantial reductions in the conviction with which their participants rated their paranoid beliefs after a six hour intervention. So, in direct opposition to the sentiments expressed by Slater and Roth (1969), the results of Watts et al. suggested that perhaps you can argue with a paranoid patient about their delusions, provided you do it carefully.

Further evidence that such challenges to delusional beliefs may be possible was provided by Milton, Patwa and Hafner (1979). They compared two groups of seven people with delusions who received either six sessions of therapy based either on the belief modification procedure of Watts et al (1973), or on a more confrontational procedure. They found that both groups showed a similar decrease in belief conviction but that the belief modification group showed continuing reductions in conviction in the six weeks following the therapy.

It can be seen therefore that the literature on CBT techniques in the area of schizophrenia, though small, offered some promise that such techniques might provide a way of helping those suffering from delusions. Since the late 1980's interest in such approaches has burgeoned. During this time new understandings of schizophrenic symptomatology have developed in parallel with more comprehensive treatment approaches and increasing evidence of effectiveness. The following three sections will consider these areas in more detail.

Changing Understandings of Schizophrenia

Central to understanding the increased interest in CBT for schizophrenia have been a number of developments in the understanding and description of these types of difficulties, particularly delusions and hallucinations. Some of these have given impetus to developing cognitive-behavioural techniques and some have themselves developed from cognitive work. Several of the more important developments are considered below.

Abandoning the Concept of Schizophrenia. A major challenge to the validity and utility of schizophrenia as a diagnostic category was proposed by Bentall, Jackson and Pilgrim (1988). These authors argued that the category of schizophrenia is problematic in four central ways. Firstly, there is evidence that it is unreliably diagnosed. Secondly, there are problems with the construct validity, as the symptoms which characterise schizophrenia do not consistently cluster together. Thirdly, Bentall et al. argued that the diagnosis of schizophrenia does not consistently predict prognosis or response to treatment (predictive validity). And fourthly that it is difficult to establish the aetiological specificity of schizophrenia (i.e. that if this is a specific disease it should have a specific cause). For these reasons, Bentall et al. argued, though further investigations of the label schizophrenia may prove it to be valid, it appeared more likely to be unproductive, both clinically, and as a focus for research.

Bentall et al. (1988) considered a more useful strategy for investigators in this area to be that of abandoning the concept of schizophrenia altogether and concentrate instead on psychotic symptoms traditionally associated with the diagnosis. (An idea first proposed by Bannister, 1968). Whether or not one agrees with this (see the Journal of Mental Health, 1993, Issues 2 and 3 for further discussion), it is clear that this shift towards a symptom focus and greater reference to "psychoses" rather than "schizophrenia" has been extremely influential in the growth of CBT in this area. Indeed Chadwick, Birchwood and Trower (1997), the authors of one of the principal practice manuals in this area, considered this symptom focus to be *the* most important catalyst to the development of cognitive approaches. The key shift they argued was that, rather than try to construct cognitive understandings of schizophrenia as a whole, psychologists have been able to concentrate on the analysis, measurement and modification of particular symptoms (a strategy which has been more productive). This focus has offered a number of new understandings and openings for cognitive treatment techniques. Some of these new understandings are considered next.

Cognitive Views of Psychotic Symptoms. There are a number of cognitive and cognitive neurological theories as to how psychotic symptoms may arise. It should be noted that, as Garety and Hemsley (1994) suggest, is seems likely that different individual formulations may involve different processes or interactions between such processes. The theories of psychotic symptoms discussed below are those which have most influenced the development of CBT treatments.

Perhaps the best known models from a cognitive-neurological perspective have been provided by Frith (1992) and Hemsley (1993), both of whom suggest that symptoms of psychotic experience result directly from neurological abnormalities. Frith's theory proposes that the primary deficits in psychotic symptoms involve an inability to distinguish internal and external sources of stimuli and to adequately represent the mental states of others (see Garety and Freeman, 1999, for a review). Hemsley's (1993) model proposed that it is the ability to assess the significance of incoming stimuli which may be impaired in psychoses leading to the attribution of less relevant stimuli which may feel alien and distressing.

Other cognitive models currently extant include Maher's (1988) account of delusions which proposes an explanation based on making sense of anomalous perceptual experience. Such experiences (which Maher viewed as primarily biological in nature, perhaps stemming from the kinds of process described above) lead individuals to seek explanations which are then developed through *normal* cognitive processes. This notion that the reasoning processes of individuals with psychoses is the same as those in "normal" individuals is central to the cognitive approach. This implication being that these processes may therefore be amenable to challenge.

Maher's (1988) theory does not, however, take account of research evidence showing that the reasoning of some people with psychotic symptoms is abnormal. A good example of this was provided by Garety and Hemsley (1994) who identified a tendency for people with delusions to jump to premature conclusions in studies of reasoning; in effect drawing

incorrect inferences from incomplete data. This may lead to greater tendency to interpret puzzling events in a negative way. However, the notion that psychotic symptoms may be comparatively normal responses to unusual experiences is quite a popular one. Fowler et al. (1995) consider a number of theories of how delusional beliefs may be shaped by learning or expectation or by misinterpretation or perceptual bias when considering events.

Negative appraisal of perceptual anomalies such as hallucinations has been at the heart of the cognitive approaches to psychosis reported by Chadwick and colleagues. Rather than concentrating on the formation of unusual experiences this type of approach focuses on the *distress* they cause. For example Chadwick and Birchwood (1994) have suggested that beliefs about the intentions (either benevolent or malevolent) of auditory hallucinations (voices) was the key determinant in the distress people experienced, irrespective of potency or content. Broadly similar results have been observed by Close and Garety (1998), though these authors found that voice content also appeared to be implicated in distress in some individuals. In both cases, however, the implication is that it is the appraisal of the symptom rather than the symptom itself which is a key variable in the suffering which results from psychotic experiences.

Emotional factors. Emotional disturbance is a common feature of psychosis and it is clear that emotional trauma may have a central impact in its development. Indeed many psychotic symptoms may seem to have particular emotional resonances in the sufferer's experience (e.g. Chadwick's, 1992, first hand account of a schizophrenic breakdown). A number of authors (e.g. Clements and Turpin, 1992; Fowler et al. 1995) have pointed out

that explanations for schizophrenia or psychotic symptoms have historically been unifactorial; stressing either the biological or the emotional antecedents. One way out of this polarised position is to adopt a stress-vulnerability model whereby biological factors (including, in some cases, genetic factors) are seen as creating a vulnerability to psychosis which can be exacerbated by adverse life circumstances (see Clements and Turpin, 1993, for a review).

An example of how emotional factors might operate in the aetiology of psychoses from a cognitive/information processing perspective has been provided by Bentall, Kinderman and Kaney (1994). They proposed that persecutory delusions may be the product of an tendency to make external attributions for negative events (even where this is inappropriate) to protect against low self-esteem (stemming from emotional experiences). While the evidence for an such an attributional bias is fairly strong (see Garety and Freeman's 1999 review) the notion that this is a defence against low self-esteem is more questionable (Freeman, Garety, Fowler, Kuipers, Dunn, Bebbington et al., 1998). This idea of delusions as defence has been taken further by Trower and Chadwick (1995) who have drawn a conceptual distinction between persecution paranoia (so-called "poor me") and punishment paranoia (so called "bad me"). These authors proposed that such delusional symptomatology serves protective functions, defending aspects of the self from a sense of insecurity and alienation. These ideas are at an early stage though Chadwick and Trower (1996) have reported preliminary evidence supporting them stemming from their own clinical work.

The area of emotional factors in the development of psychosis is clearly important and it may be that, from a cognitive point of view, the functionality of particular symptoms will become a great deal clearer with further research. This may be an area where there is the possibility of fruitful cross-fertilisation of cognitive and psychoanalytic ideas. Hingley (1997) in particular has argued that a number of key psychoanalytic concepts such as defence mechanisms and a vulnerable ego may be of great value in taking cognitive views of psychosis towards a deeper understanding of emotional factors.

Employing These Factors in CBT Treatment. These changing understandings of schizophrenia, and particularly of psychotic symptoms, have influenced the development of CBT in a range of ways. More cognitive-neuropsychological approaches and models stressing psychotic symptoms as a response to events open up the possibility of sharing these ideas with sufferers to help re-interpret symptoms. Evidence of the types of reasoning and appraisal errors which people may make, and the importance of this in the distress that symptoms cause, provides a basis to challenge the evidence for these types of thinking errors. Perhaps this helps to explain the success of some earlier CBT work (e.g. Watts et al., 1973). Stress-vulnerability models also provide a means for sufferers to make sense of symptomatology. Understandings of particular emotional problems can aid individual formulation and help in understanding the function or meaning of symptoms for particular individuals. In the following section the therapeutic methods which have arisen from these understandings of psychotic symptoms are considered in more detail.

Therapeutic Approaches

It has been argued by Garety et al. (2000) that that all of the main CBT approaches to working with psychosis have at their heart the aim of reducing the distress and emotional disturbance associated with psychotic symptoms and enhancing active participation in reducing risk of relapse and social disability. The focus is not on reducing psychotic symptoms *per se* but on changing distressing meanings which produce suffering. All of the approaches discussed below draw extensively on the cognitive therapy principles outlined by Beck and colleagues (e.g. Beck, Rush, Shaw and Emery, 1979); that of a collaborative rationale to achieve shared understandings.

There have been three practice guides providing detailed descriptions of CBT for people with psychotic symptoms: Kingdon and Turkington (1994), Fowler et al. (1995), and Chadwick et al. (1997). Additionally Tarrier and his colleagues have developed a broadly CBT approach (see Yusupoff and Tarrier, 1996). Though there is a great deal of overlap in terms of the goals and methods of these therapies, there are some differences in emphasis.

The approach outlined by Fowler et al. (1995) is perhaps the most broadly based in terms of technique and will serve to illustrate the main features of CBT in this area. This approach involves a guiding framework of six main stages which can be applied flexibly, returning to earlier stages and tasks as necessary. The stages are as follows:

1. *Engagement and Assessment*. Though an important feature of all therapy, engagement is particularly emphasised by most authors in this field. As well as clients being suspicious as a result of their particular difficulties they may often have a lengthy and difficult history of experiences with mental health services. Fowler et al. stress the particular importance of initially accepting the client's belief systems and of making sessions tolerable for clients (e.g. through using shorter time slots if necessary). The process of engagement then develops into more structured assessment, identifying and understanding key symptoms understanding and agreeing shared goals.

2. *Coping strategy work*. The process of CBT generally commences with the development of coping strategies for the various target symptoms. These can include a wide range of cognitive and behavioural methods such as activity scheduling, relaxation, distraction techniques and many others. The emphasis here is on testing out and using techniques which work for particular individuals. Attention is given to bolstering people's own coping strategies where these have proved effective. This kind of a approach was also developed by Tarrier and colleagues (Yusupoff and Tarrier, 1996).

3. *Developing a new understanding of experience*. At this stage the intention is to construct, with the client, a new and less distressing formulation of the symptoms than the one they already have (e.g. a supernatural explanation). Many of the understandings of symptoms discussed above can be employed. For example the linking of psychotic symptoms as a result of neurological factors or emotional events, a framework of stress-vulnerability, and attempts to "normalise" symptoms as a response to circumstances (cf. Kingdon and Turkington, 1994, see below) may all be useful. Clearly some of these explanations described may be helpful to some people whilst the

same explanation (e.g. the notion of a neurological abnormality) might actually be distressing to others. It does appear that the CBT approach, particularly as outlined by Fowler et al., is however extremely pragmatic in relation to the alternatives offered concentrating on those that will reduce distress above all else.

4. *Working on delusions and hallucinations*. The next stage in this model of therapy is more intensive work on beliefs relating to delusions and hallucinations which, as described above, may be pivotal in maintaining distress. Factors considered here may include the kinds of reasoning biases it is hypothesised the client may be using (cf. Garety and Hemsley, 1994) and the mis-attributions that may be made and the emotional consequences of belief change (cf. Bentall, et al., 1994). The core techniques at this stage include: reviewing the evidence for key beliefs (cf. Watts et al., 1973), reality testing of evidence and, where change may still be resisted, working within beliefs to try and minimise their most distressing aspects.

5. *Addressing mood and negative self-evaluation*. On the basis of theories of the protective function of psychotic symptoms discussed above (Bentall et al., 1994; Trower and Chadwick, 1995), this model of therapy also stresses the need to assess, and if necessary modify, negative beliefs and about *the self* (e.g. beliefs relating to self-worth). Once formulated, it may be possible to modify such beliefs using more traditional cognitive means such as those described above.

6. *Managing risk of relapse and social disability*. This final stage involves reviewing the nature of the work done with particular clients and discussing in detail how this may be applied to a range of situations in future. Areas which may be discussed include a

review of the formulation; stressing the importance of active participation in maintaining recovery; clarifying goals; and anticipating potential problems.

Other authors working in this area have developed some of these elements further. For example, Chadwick et al. (1997) have particularly concentrated on the measuring and modifying of beliefs relating to delusions and hallucinations. These authors have also begun to develop a model of psychotic symptoms as functionally protecting the self (cf. Trower and Chadwick, 1995). Other approaches include that of Kingdon and Turkington (1994) who have outlined a model which emphasises a so-called "normalising rationale" (p. 9). This utilises a stress-vulnerability model and helps clients towards an understanding that there may be more benign reasons for their symptoms in order to counter distressing beliefs and try to de-stigmatise the experience of psychosis.

Outcome Research

The development of the therapies described over the last decade has gone hand in hand with a number of investigations of the effectiveness of single techniques, and packages of techniques, on the management and reduction of psychotic symptoms. Particularly in the early stages of investigations a number of these have employed single-case methodologies and case series analyses. Some examples of this kind of work are given below. As with the theories of symptomatology most of these have focused on delusions and hallucinations (cf. Bouchard, Vallières, Roy and Maziade, 1996).

Examples of single case methodologies. Following the early work of Watts et al. (1973) and Milton et al. (1979) later investigations include that by Fowler and Morley (1989)

who reported an attempt to treat five people suffering from chronic hallucinations and delusions. After a treatment employing belief modification and coping strategy work, given in weekly sessions over 14 weeks, they found that one person out of their sample changed her belief about her hallucinations and she, along with three others, reported increased ability to control them.

A number of single-case studies have been conducted by Chadwick and his associates. For example, Chadwick and Lowe (1990), found that verbal challenges and reality testing either reduced conviction in, or eliminated, delusional beliefs in five out of six individuals. Further work by these authors (Chadwick and Lowe, 1994), found that reality testing did not appear to reduce belief conviction significantly on its own but was effective when used following verbal challenge. Such results have received support from Sharp, Fear, Williams, Healy, Lowe, Yeadon et al. (1996) who treated six people with delusions using belief modification procedures based on Chadwick et al. 1997. Three of their sample showed reduced belief conviction.

Controlled trials. As interest in the use of CBT in this area has developed there have been a number controlled trials investigating the efficacy of the approach. Though this methodology can be criticised for the difficulties in external validity (generalising from the trials to actual practice- see Roth and Fonagy, 1996), it is clearly essential in establishing the effectiveness of treatment methods.

Smaller non-randomised trials include that by Tarrier, Beckett, Harwood, Baker, Yusupoff and Ugarteburu (1993) who considered a group of 27 people diagnosed with chronic schizophrenia and medication resistant. They compared five week treatments with either a

coping strategy enhancement (CSE) or problem solving (PS) treatment to a waiting list control. Both treatment groups improved significantly in terms of overall symptomatology and the coping strategy group showing greater improvement at six month follow up. At end of treatment 60 percent of the CSE group had shown a decrease in symptoms of 50 percent or greater. A second encouraging waiting list controlled trial reported by Garety, Kuipers, Fowler, Chamberlain and Dunn (1994) also considered individuals with drug-resistant psychotic symptoms. This study compared 11 people who received CBT (16 sessions, based on the Fowler et al., 1995, model) to seven waiting list controls receiving a standard treatment. Garety et al. (1994) observed that the therapy group improved significantly in comparison to controls on a range of symptoms including depressions and particularly in terms of delusional convictions.

More recent randomised control trials (RCTs) include the study of Drury, Birchwood, Cochrane and MacMillan (1996a) who reported a significantly steeper decline in both self-reported and observed positive symptoms in a group of 20 patients suffering from acute psychotic episodes (receiving treatment based on Chadwick et al. 1997 focusing on belief challenge and also family support) when compared with a similar group of 20 individuals receiving a package of recreation and support. A follow up of the same sample by Drury et al. (1996b) suggested a swifter recovery time in the CBT group over six months .

A further major RCT based in London and East Anglia (Kuipers, Garety, Fowler, Dunn, Bebbington, Freeman et al., 1997) has supported this result with a larger sample (in this case 60 people with medication-resistant symptoms and a CBT treatment package based on Fowler et al., 1995) over a nine month period. They reported that as well as showing a greater average improvement on the main measure of positive psychotic symptoms, 40

percent of the CBT group showed significant improvement on this main outcome measure compared to only three percent of the routine care control sample. In an 18 month follow-up (Kuipers, Fowler, Garety, Chisholm, Freeman, Dunn et al. 1998), the CBT group still showed a significant advantage on this measure.

A larger RCT has also been conducted by Tarrier, Yusupoff, Kinney, McCarthy, Gledhill, Haddock et al. (1998). Their sample of 72 people split into three groups receiving CBT, supportive counselling or routine care. They found that 33 percent of the participants in their CBT group showed a significant improvement (defined as 50 percent better on their main outcome measure), compared to 15 percent of the supportive counselling group and only seven percent of the routine care group.

The most recent published RCT has been conducted by the Kingdon and Turkington group (Sensky, Turkington, Kingdon, Scott, Scott, Siddle et al., 2000). This trial considered 90 people with medication resistant psychotic symptoms. The treatment group received nine months of CBT (based on the Kingdon and Turkington, 1994 model) compared to a befriending intervention. At the end of the treatment period both groups showed substantial reduction in positive symptoms with no significant differences between them. At 9 month follow-up, however, the CBT group showed significantly greater improvement with 63 percent showing 50 percent improvement compared to 17 percent in the befriending group. While both this study and the Tarrier et al. (1998) trial show benefits of more generally supportive interventions, CBT treatments clearly appear to benefit a greater number of people with better maintenance effects. All of the controlled trials reviewed however suggest that these kinds of gains are a great deal more pronounced with positive than negative symptoms.

As well as these outcome studies there have been two systematic reviews of the outcome literature in this area: Bouchard, et al. (1996), who reviewed literature up to 1994 and Jones et al. (2000), a review issued by the Cochrane Library, concentrating on RCT studies up to 1998. Each of these reviews was based around the principle of eliminating studies on the basis of methodological short comings. Bouchard et al., who considered studies on the basis of reliable diagnosis of schizophrenia, adequate measurement of symptoms, and a range of reliability measures, concluded that these types of interventions were effective when people with these types of delusions were capable of rational thought. Jones et al., who focused on the larger scale RCTs discussed, concluded that CBT for schizophrenia is associated with a substantial (54 percent) decrease in chances of relapse and are also broadly optimistic about the potential of this treatment.

Factors Involved in Outcome from CBT

Though there is now a substantial body of evidence to suggest that CBT techniques may be effective in addressing the severity of positive psychotic symptomatology there is still a limited amount of data on the factors involved in a successful outcome. A number of RCTs have shown a substantial portion of people who have failed to respond with significant improvement (ranging between 27 and 67 percent). The question of why there should be this proportion of people who do not progress is an important for two reasons. Firstly, it is central to the consideration of how success rates might be improved, and secondly considering both successful and unsuccessful therapies provides information as to how this kind of therapy actually works to achieve change.

Several studies have attempted to address this issue. Chadwick and Lowe (1990), in a small scale case series analysis, considered that the ability to question delusions in the face of hypothetical contradiction may be a predictor of treatment success. A related finding in another case analysis conducted by Sharp et al. (1996) also sheds light on this area. Improvement in this study was positively associated with the "Belief Maintenance Factors" sub-scale of the Maudsley Assessment of Delusions Scale (MADS - Wessely, Buchanan, Reed, Cutting, Everitt, Garety et al. (1993). This measures an individual's ability to identify internal and external factors which maintain his or her belief and also the ability to hold alternative views.

The London East-Anglia trial (Garety et al., 1997), also considered a range of predictive variables for their groups. The key predictors of a good outcome in the CBT group were firstly, (and similar to the observations of Chadwick and Lowe, 1994) a willingness to admit being mistaken about psychotic beliefs (again based on the MADS), and secondly, a greater number of recent hospital admissions. This latter finding was not predicted (as severity of illness was not associated with outcome). Garety et al. hypothesised that increased hospital admissions might signal increased instability of psychosis which might results in greater opportinity to modify beliefs. This finding however looks as if it is somewhat atypical as it is at odds with the result of Tarrier et al. (1998) who found that a short duration of illness and fewer hospital admissions were significant in good outcome. The results of Tarrier et al. (1998) were also at odds with the findings of Tarrier et al. (1993) who suggested that individuals with higher psychotic symptom scores improved more than those with lower symptom scores. It should be noted however that these

predictors in Tarrier's studies were associated with improvement in both CBT and control groups.

It can be seen therefore that the one fairly consistent factor which emerges from the consideration of factors involved in positive outcomes is a willingness to consider alternative explanation for psychotic phenomena. However, as with work on emotions, further research clearly appears to be required.

Research Aims

The present study took up this final point and its primary goal was to expand understanding of factors involved in good and poor outcomes in CBT with psychotic symptoms. Studies such as those of Garety et al. (1997) have been reliant on anticipating what factors might affect outcome and then considering them at the end. In this case, rather than attempt to consider a range of measures pre-therapy, this study took the rather different approach of asking individuals who have participated in this type of CBT (resulting in good or poor outcomes) for their reflections on the process. The intention of utilising such a method was to generate new ideas as to factors which may be implicated in outcome (see following section).

Choice of methodology. The study described in this report employed a semi-structured interview with therapists and clients rather than a more structured interview or questionnaire methodology. This method was chosen for two reasons. Firstly, rather than anticipating what factors may be involved in outcome, the main concern was to generate data across the broadest field possible by generating ideas out of the experiences of participants in the therapeutic process. Secondly, through considering the views of clients

as well as therapists it was intended that the study should attempt to record some of the experiences of service users who have received this kind of therapy. To date there has been little consideration of this type of data for CBT with psychotic symptoms. (The satisfaction measures in the London-East Anglia trial are an exception). User-perspectives may offer another important element in the overall evidence-base for these types of therapies.

Clearly the kind of methodology employed also has its limitations. Unlike for example RCTs, the actual impact of outcome factors on the therapy is not established in a controlled fashion. However, as well as the different kinds of information this methodology may produce, it may be seen as complementary to other methodologies in that it may also provide further hypotheses on which to base more controlled investigations.

Encouragement in the use of such interview methods also comes from the increasing recognition of the usefulness qualitative analysis methods in psychology (e.g. Hayes, 1997) as a tool for analysing the content and meaning of more discourse based data. The term qualitative covers a family of techniques which provide rigorous means of analysing such data. Such methods are based on a paradigm of epistemological constructivism. Though methods differ, the overarching aim of such a paradigm is to investigate how meanings and understanding are constructed in experience (see Henwood and Nicholson, 1995). There is, as Smith (1995) has argued, often a natural fit between such methods and interview based data and this family of analysis techniques. The choice of analytic framework is discussed further in the Method.

Research Questions.

The primary research aim was to expand understanding of factors involved in good and poor outcomes in CBT with psychotic symptoms. The particular focus of the project was the attempt to develop a clearer picture concerning what was *different* about the therapies of individuals classed in these two groups. The study considered factors emerging from accounts of the therapeutic process of CBT for psychosis from both therapists and clients. These clients were grouped into those with good an poor outcomes. A comparison of the factors emerging from accounts of differing outcomes was intended to provide a basis on which to answer one central question:

- What factors observable in accounts of the therapeutic process differentiate between individuals who have progressed in CBT for psychosis and individuals who have not managed to progress in this therapy?

Method

Design

The data in this study was collected from participants in eight therapeutic dyads who had been involved in using CBT methods to treat psychotic symptoms. Accounts of experience of such therapy were collected through individual interviews with therapists and two each of their clients: one who had progressed in therapy and one who had failed to progress. This is known as the principle of triangulation of data sources (i.e. seeking data from multiple sources; Bannister, Burman, Parker, Taylor and Tindall, 1994). Collecting data from these different perspectives was intended to both enrich the data upon which to build an account of differences between the groups and to help safeguard the validity in the interpretation of the data (one of several methodologies to aid validity suggested by Stiles, 1993).

The data generated by the interviews was analysed using a grounded theory methodology (Charmaz, 1995; Henwood and Pigeon, 1995; Strauss and Corbin, 1998). This provides strategies for developing categories and eventually theories by building (or "grounding") on a fine-grained consideration of small units of data (such as lines or phrases).

The grounded theory methodology was chosen for three reasons.

1. As a qualitative methodology it provided a framework to assess individual meanings and discourse: to, as Smith (1995) has suggested, allow researchers to "capture the richness of the themes emerging from the respondents' talk" (p. 9).
2. As a way of helping to ensure rigour and control subjectivity in the interpretations of this kind of data (see the recommendations of Mayes and Pope, 1995; Stiles, 1993).

3. To provide a means to develop emerging themes into a more formal theoretical framework. A theory not only implies a descriptive and explanatory framework but also a series of testable hypotheses. Such a theory would be able to provide the basis for further (perhaps more quantitative) investigations in this area.

Participants

Therapists were contacted on the basis that they were known to work using CBT to treat psychosis. Ten therapists from three NHS trusts, all of whom had conducted CBT to treat clients with psychotic symptoms were approached and each was asked if they could suggest two of their clients to participate in the study. Nine therapists agreed to participate. Of these, four were unable suggest appropriate clients and one further therapist did not meet the inclusion criteria (see below). The remaining four therapists and eight of their clients were the participants in the study.

Sampling. The study employed "systematic, non-probabilistic sampling" (Mayes and Pope, 1995, p. 110). The purpose of this is to identify potential participants who possessed characteristics relevant to the purposes of the investigation, rather than to select a random or representative sample.

Selection criteria. Therapists were selected on the basis that:

1. They had identified themselves as having conducted CBT for psychotic problems.
2. They were able to suggest two clients they had seen who conformed to the client selection criteria (see below) as participants.
3. They were willing to have their interviews and interviews with their selected clients audio taped.

As this investigation dealt with therapies that were either ongoing or completed there was no opportunity to look at standardised treatments where the specific elements of the therapy are controlled as part of the study. It was therefore necessary to ensure that the therapists in the investigation had delivered genuinely CBT treatments. This need led to two further therapist selection criteria:

4. Therapists were required to have completed formal training in CBT. In practice all therapists were clinical psychologists, which qualification was considered evidence of appropriate training.
5. Therapists were required to have had further CBT training and/or supervision specifically in CBT for psychosis from the authors of one of the main practice manuals discussed in the introduction.

Clients were selected according to the following six criteria:

1. They had at least one positive symptom of schizophrenia according to DSM-IV
2. They had received treatment for their symptoms using CBT methods with an appropriately qualified therapist.
3. Their outcome in therapy was defined as having either "made significant progress" or "failed to progress or worsened".[1]

[1] Originally it was intended that the judgement of progress or otherwise in therapy would be made on the basis of questionnaire outcome measures used in the published literature (e.g. the Brief Psychiatric Rating Scale, Overall and Gorham, 1962). However, in practice no such measures were available for any of the clients considered. The assessment of outcome was therefore made in the judgement of the therapist concerned.

4. They had either completed or almost completed therapy or, in the opinion of the therapist, "substantive work had been completed".[2]
5. Completion (if completed) has occurred no earlier than 3 months before the research interview.
6. They were willing to participate in the study and agreed to the conditions outlined in the Consent Form (Appendix 1).

Participant characteristics.[3] Information about the participants gathered in the interviews is summarised below. (see Tables 1.1, 1.2 and 1.3). Therapists are designated with a "T", clients who progressed with a "P" and clients who did not progress with "NP".

Therapists

Therapist Identification	Sex	Service context	CBT models influencing practice
T1	M	Community psychiatric rehabilitation service	Chadwick et al (1997)
T2	F	Community psychiatric rehabilitation service	Chadwick et al.
T3	F	Outpatients	Fowler et al. (1995)
T4	F	Acute admissions/Outpatients	Fowler et al.

Table 1.1. Information on therapist participants.

Clients

Client ID	Age	Sex	Therapist	Context in which seen for therapy	Therapy complete
P1	42	M	T1	Community residential	Y
P2	37	M	T2	Community residential	Y
P3	44	F	T3	Acute ward and outpatients	N
P4	36	F	T4	Outpatient	Y

Table 1.2. Clients who made progress in therapy.

[2] Outcome clearly implies a finished therapy. However in practice, as a number of such clients are seen on a long term basis stipulation of finished therapies once again proved impractical. Judgement of "substantive work" was again a matter for the therapist. Clients were also seen for short contracts during acute admissions. Because of the highly variable nature of the therapies on offer in real clinical settings no minimum or maximum length of therapeutic contact was stipulated for those who had progressed. Those who had failed to progress were required to have had a minimum of 12 sessions (a criterion drawn from the RCT literature).

[3] All details which could identify participants have been removed throughout the report.

- P1 had been seen for therapy on a weekly basis for a year and a half. His primary symptoms were auditory hallucinations and delusions which had persisted for an unknown number of years. *Medication:* Respiridone (anti-psychotic) 8mg.[4]
- P2 had been seen on a weekly basis for one year. His primary difficulty was auditory hallucinations. These had been occurring since his early 20s. *Medication:* Clozapine (anti-psychotic) 800mg, Sodium Valporate (anti-epilepsy) 800mg.
- P3 had been seen for approximately eight months on a weekly basis. Her difficulties were defined as persecutory delusions. Her difficulties dated back three years. *Medication:* Olanzapine (anti-psychotic) 10mg, Paroxetine (anti-depressant) 20mg.
- P4 had been seen on half a dozen occasions over a four month period. Her difficulties were defined as persecutory delusions which appeared to date back to her mid 20s. *Medication:* Stelazine(anti-psychotic) 15mg.

Client ID	Age	Sex	Therapist	Context in which seen for therapy	Therapy complete
NP1	40	M	T1	Community residential	Y
NP2	38	M	T2	Community residential	N
NP3	37	F	T3	Outpatients	N
NP4	26	F	T4	Acute ward	Y

Table 1.3. Clients who did not progress in therapy.

- NP1 was seen for approximately a year on a weekly basis. He suffered from auditory hallucinations. These difficulties had persisted for approaching 20 years. *Medication:* Clozapine (anti-psychotic) 700mg, Respiridone (anti-psychotic) 6mg.
- NP2 was seen for a year and a half on a weekly basis. The primary focuses of this work were considering the effect of auditory hallucinations and an attempt to establish the

[4] All doses daily.

truth of a number of memories. NP2's auditory hallucinations had been occurring for approximately 12 years. *Medication:* Clozapine (anti-psychotic) 400mg.

- NP3 had been seen for approximately one year. His primary symptoms were self-aggrandising delusions and auditory hallucinations. These symptoms had been in evidence since his mid-teens. *Medication:* Olanzapine (anti-psychotic) 10mg, Sertraline (anti-depressant) 50mg.
- NP4 had been seen for 12 sessions over approximately five months. Her primary symptoms were persecutory delusions and the perception that she could broadcast her thoughts. She had been experiencing these difficulties for approximately six years. *Medication:* Clozapine (anti-psychotic) maintained at blood level of 0.35mg/litre.

The Interview Schedule

The interviews were based on semi-structured schedules (Appendix 2). The wordings given were altered for understanding where necessary. There were parallel schedules for the therapists and clients. A set of appropriate subject areas was developed on the basis of the research questions, the literature on factors implicated in outcome in cognitive therapy and consultations with four clinical psychologist colleagues, all of whom worked with people with psychotic problems. The schedule for clients was piloted on two trainee psychologist colleagues who answered on the basis of their personal experience as clients in psychotherapy.

Following the recommendations of Smith (1995), the schedules were designed to facilitate reflection using open, neutral questions. The questions did not use jargon or any illness labels. This use of non-medical language was particularly aimed at the clients to attempt to elicit the individuals' interpretations of their experiences and their therapy rather than

imposing an "illness" discourse on them. Prompts following questions were intended to elicit more specific information if this was not forthcoming from more open questions: a technique Smith referred to as "funnelling" (p. 15). The sequence of items was also designed on this funnelling principle, commencing with items intended to prompt general reflection and moving onto more specific items utilising constructs provided by the interviewer such as "helpfulness".

The items in the interview schedule were intended to elicit reflections from therapists and clients in the following areas of clients' experience in therapy:

- Asking for an account of the therapy. This item was intended to elicit differing perspectives on the therapy, setting as few expectations as possible as to what were appropriate answers.
- The circumstances which led to the therapy taking place (including views about what difficulties they had experienced).
- Expectations of the therapy.
- Perceptions of the fit between the clients' expectations and what took place.
- Reflections of what the client found helpful and less helpful about the therapy.
- Views on the therapeutic alliance between therapists and clients. This item included specific prompts on trust, confidence and a sense of shared goals, argued by Agnew-Davies, Stiles, Hardy, Barkham and Shapiro (1998) to be the three main factors in formation of such alliances.
- Perceptions of the therapeutic techniques employed and their purpose.
- Judgements as to how the client was now.
- Reflections on emotional responses of therapists towards clients.

Procedure

Ethics. Ethical approval was provided by the Local Research Ethics Committees of the three trusts concerned (Appendix 3). Particularly salient ethical issues were: the information given to the clients as to the purpose of the study; the potential distress which might be caused to participants by talking about difficult experiences; and potential distress caused by the presence of an audio recorder to people with paranoia.

Apropos of the information given to clients, the client participants were *not* informed that the purpose of the study was to consider CBT for psychosis. This was because it was felt that this information (i.e. saying that the investigation was looking at psychosis) would inhibit them giving their own interpretations of their experience and of the therapeutic contact (see discussion of question forms above). Client participants were told that the study was an investigation into experiences of psychological therapy. The two remaining ethical issues discussed above were addressed by taking steps to minimise the possible distress clients might feel. The clients were provided with written information and opportunities to ask questions (see below). In the explanations to therapists and clients, particular emphasis was paid to the uses to which the recording would be put and the participant's right to withdraw from the study at any time.

Recruitment. The participating therapists approached clients on or recently discharged from their caseloads and asked them if they would be willing to be approached by the investigator. Those who answered affirmatively were contacted by letter (Appendix 4) and provided with an information sheet (Appendix 5). This explained the general form and

purpose of the study. The letter was followed up by telephone which provided an opportunity for client participants to ask questions and for an interview date to be arranged.

Interviews with therapists took place at their main work base and seven of the interviews with clients took place at the community housing in which they lived. One client came to be interviewed at the investigator's work base. Before interviews the clients had the chance to read the consent form in the presence of an independent observer. This included agreement both to audio taping of the interviews and for the investigator to talk to their therapists about their therapy. They also had the chance to ask any further questions they might have. Interviews with clients took between 40 and 50 minutes (with the exception of one client who took 15 minutes). Interviews with therapists (during which they discussed both clients) took between 60 and 75 minutes.

Interviews were recorded using a digital minidisk recorder which provided high quality reproduction. Literal transcription of the recordings was undertaken by the author in line with the recommendations of Strauss and Corbin (1998). Also following a suggestion of Strauss and Corbin, the author recorded impressions in field notes after each interview (Appendix 6).

Data Management

The methods used in the grounded theory analysis were as follows.

Open coding. This refers to the process described by Strauss and Corbin (1998) as identifying concepts and their properties in the data. This process commenced with

reading the transcripts of the interviews several times. This was followed by microcoding (sometimes known as line by line coding) which involves labelling small units of data (such as words or phrases). This provided the foundation for focused coding; a process of generating codes to describe larger sections of data. Of central concern at both of these stages was clear definition of the codes including the processes they described and the assumptions implicit within them.

Axial coding. This referred to the process of generating a small number of higher order main categories to describe the main themes emerging from the data. These categories were then refined and structured with the incorporation of sub-categories and sub-dimensions to describe differences in data included under each main category heading.

Selective coding. This process involved the generation of a main overall theme from the data to link the categories generated at the axial coding stage.

Theoretical sampling. This more specific form of systematic non-probabilistic sampling refers to using codes and categories emerging from analysis of the data to guide further data collection. In this case ideas emerging from the process of axial coding were explored with later participants.

Memo writing. Memos consisting of written descriptions of codes and categories emerging from the data set provided a means to explore and refine ideas as the analysis progresses. Though memos were employed at all stages of the analysis they were of particular use as an aid to developing the main categories generated during axial coding

and themes generated during selective coding. The memos used to help generate the main data categories and the overall theme are reproduced in Appendices 7 and 8.

Methodological Rigour

A number of recent papers have addressed this area of qualitative research (Elliott, Fischer, and Rennie, 1999; Mayes and Pope, 1995; Stiles, 1993). Stiles (1993) has drawn a distinction between methods which help trustworthiness of observations and data (reliability) and methods assisting trustworthiness of interpretations (validity). The triangluation of data sources and the "grounding" of ideas in a fine grained analysis of the data itself are both recognised means of controlling subjectivity. A number of other steps listed below addressed one or both of these dimensions of rigour.

Inter-rater reliability. An independent rater was asked to classify samples of the transcripts into codes identified by the author. Inter-rater agreement was based on the concordance between these two sets of ratings.

Transparency of researcher's expectations. It has been argued by Charmaz (1995) and many others that the subjectivity of an investigator will inevitably influence the results of an investigation such as the present one. A potential way to address this is to make potential biases of the researcher in the collection and interpretation of the data as clear as possible those who will read the analysis. To make any potential biases clear the views of the author about the project as it developed were recorded in a Research Diary (Appendix 9). The diary is a record of the researchers expectations of and ideas about the project compiled during the time period from the initial development of the project to the completion of the report.

Auditability. Continuing the theme of transparency in the analysis steps were taken to allow readers to judge the validity of the interpretations placed on the data. This was addressed by providing examples the micro and focused coding process via an annotated transcript of an interview (Appendix 10) and extensive examples of quotations allocated to the main categories (Appendix 7).

Peer debriefing. The involvement of a supervisor in the development of the coding scheme and regular reporting of emerging findings to a group of professional colleagues provided an external check on the analysis.

Respondent validity. Three of the participants (one from each of the groups) were interviewed a second time and asked to make judgements on the accuracy of the main categories emerging from the analysis.

Applicability. A further validity criterion was the extent to which the results of the analysis had realistic applications to this field. This was considered in terms of clinical implications and in terms of the generation of ideas for further research investigation.

Falsifiabilty. A final consideration in the analysis was a concern to examine the data for negative or deviant cases which contradicted elements of the emerging structure. Popper (1959) has argued that the search for such cases is essential in any rigorous scientific investigation.

Results

This section briefly describes the processes of open and axial coding which were used to analyse the data. This is followed by an account of the main categories and their sub-categories and sub-dimensions generated from the interview data. Sample quotations illustrate the categories. The process of a selective coding and the development of a central theme integrating the categories is then described. In the final part of this section a summary of the results from the inter-rater reliability and respondent validity studies is provided.

Open Coding

The process of micro coding each of the 12 transcripts generated a total of approximately 1,700 distinct codes. It should be noted that a large number of these were the product of minor differences in phraseology. These micro codes were used to build up approximately 200 distinct focused codes which described processes occurring in larger segments of data. One transcript and the micro and focused codes generated for it are given as an example in Appendix 10. Emergent themes from the focused codes were used to generate the six main categories described below.

Axial Coding

For each main category sub-categories and then sub-dimensions were developed. In view of the large volume of data, the analysis reported here primarily concentrates on categories which clearly distinguished between the progressors (P) and non-progressors (NP). This strategy arose directly from the research question which sought information on the factors

in the therapy which were different for those with good and poor outcomes in CBT for psychosis.

Categories emerging from the data which were rejected during the development of the scheme as failing to distinguish between the two groups included: therapist perception of good client social skills; high expectations from therapy; nature of beliefs (e.g. that symptoms were either punishing or persecutory); improvement due to medication; and identification of problems as illness. There was a mix of P and NP clients in each of these categories. For example, while all of the P group were able to identify some sort of illness model as the cause of their difficulties, three of the NP group also identified their difficulties as stemming from illness. This suggested that possession of (or acquisition of) an illness model was not a significant factor in making progress in CBT for psychosis. The importance of interpretation of condition is discussed at greater length with regard to Category 2 (see below).

Main Categories Emerging from the Data

Six main category headings were developed to describe the major observable areas of difference in the discourse of and about the P and NP groups. These are reported below. Full quotations from all participants who mentioned particular sub-categories and sub-dimensions are given in Appendix 7.

Category 1: Definitions of progress. Before beginning to elaborate the other codes which distinguished the P and NP groups, a central concern was to consider the criteria by which the therapists had selected people for these groups. Therapist discourse in this area fell into two main sub-categories:

1A. Description of progress or failure to progress in broadly CBT terms. This referred to areas specifically targeted by CBT for psychosis (see Introduction) such as reduced distress or changed beliefs about symptoms. For sub-category 1A, sub-dimensions identified from *therapist's* discourse are provided in Table 2.1.

1B. Description of progress or benefits in non-model specific terms. This referred to more general definitions of success such as sustained engagement and the benefit of the client being listened to.

	Number of clients mentioned by <u>therapists</u> in each dimension		
Sub-dimensions	**P Group**	**NP Group**	**Sample Quotations**
Changed interpretation of symptom	4	-	<u>T2 on P2:</u> *"I was defining success ... in terms of a shift in P2's understanding of his difficulties to an explanation that seemed less distressing for him."*
Changed means of dealing with symptom	2	-	<u>T4 on P4:</u> *"She did say that she'd got stressed... so she was happier to take medication for that".*
Reduced distress relative to symptom	2	-	<u>T2 on P2:</u> *"He seems to have more of an understanding of what these experiences are. More of an understanding that is less frightening to him."*
Managing mood variations	1	-	<u>T3 on P3:</u> *"Certainly she has some blips in her mood depending on what's going on externally. But sort of seems to manage that really well."*
Practical improvements	1	-	<u>T3 on P3:</u> *"She's doing the kinds of things that she needs to be doing."*
No changed interpretation of symptoms	-	3	<u>T2 on NP2:</u> *"We haven't managed to change how he sees it."* <u>T4 on NP4:</u> *"she was 60% sure it was the IRA, 40% it was schizophrenia. She did think that she probably was ill... But in the end it was still the IRA."*
Therapist does not feel there is an improvement	-	2	<u>T4 on NP4:</u> *"I didn't get anywhere really with NP4."*
No CBT engagement	-	1	<u>T1 on NP1:</u> *"I don't think I really was able to engage him.. in the way I might have liked to have worked i.e. in a kind of CBT way."*

Table 2.1. Sub-category 1A: Therapist's descriptions of progress or failure to progress in CBT terms.

It is clear from Table 2.1 that therapist discourse indicating progress in CBT terms was applied to the P group in CBT terms but not to the NP group. On the other hand they used discourse indicating failure to progress for the NP group. This is hardly surprising as the therapists were asked to select clients who had either progressed or not progressed in CBT. Furthermore, therapists defined the P clients' progress in a homogeneous way. In particular, all of the P group were identified as having *changed their interpretation* of their symptoms to a less distressing explanation (in all cases to an illness model). Three of the NP group were said not to have changed their interpretation and no descriptions of a change of interpretation were given for the remaining two. In view of the absence of standardised measures of outcome it is therefore important that there were apparently clear and consistently applied criteria in therapist judgement of success.

The interviews with clients broadly supported what the therapists said, as three of the clients from the P groups were able to describe their success in CBT terms, whereas clients in the NP group were not (See Table 2.2).

	Number of clients expressing discourse in each dimension		
Sub-dimensions	**P Group**	**NP Group**	**Sample Quotations**
Help from increased understanding	1	-	P1: *"I: Can you tell me about seeing T1 for therapy?* *P1: I like him. I think he's very helpful. He's helped me understand the voices more."*
Changed interpretation of symptoms	2	-	P4: *"She... was helping me to change my thought patterns to perhaps perceive something in a different way... They were quite useful interviews"*
Successful problem solving	1	-	P3: *"I wanted to be able to find a way of dealing with the problem of sorting out for myself what was really about my memories and what was false about them. And T3 has helped me do that."*
Reduced distress relative to symptom	1	-	P1: *"I prefer the new explanation [it's] less frightening than Satan... A trick of the mind doesn't seem so frightening"*

Table 2.2. Sub-category 1A: Client's descriptions of progress in CBT terms.

Sub-category 1B of "definitions of progress" was the description by therapists of a range of non CBT specific benefits. Three of the therapists considered that their P group client had benefited from non-specific factors such as having their experiences taken seriously. However three of the therapists also considered that the clients they had seen in the NP group had found non-specific aspects of the therapy useful, particularly in terms of the benefits of contact with a therapist. This is shown in Table 2.3.

	Number of clients mentioned by <u>therapists</u> in each dimension		
Sub-dimensions	**P Group**	**NP Group**	**Sample Quotations**
Usefulness of turning up	1	-	<u>T1 on P1:</u> *"P1's expectations were simply that I would turn up and he felt that was useful."*
Usefulness of taking experiences seriously	2	-	<u>T4 on P4:</u> *"at least she had the experience of not having someone say 'you're deluded, go away'."*
Providing social contact	-	1	<u>T1 on NP1:</u> *"I was helping him by being an intelligent person who'd have a chat with him."*
Ability to see other people as real and permanent	-	1	<u>T2 on NP2:</u> *" but it is seemingly successful in other ways... if it becomes possible for him to feel more certain about my reality and my role for him that it may also be possible therefore to see other people in those terms which then opens up possibilities."*
Continued engagement useful	-	1	<u>T3 on NP3:</u> *"It has been successful in the sense that he's engaged and he's talked about it and that he carries on coming which is a good thing."*

Table 2.3. Sub-category 1B: Therapist's descriptions of progress in non-specific terms.

Members of both groups of clients also appeared to value the non-specific aspects of the therapy. Two of the P group described the usefulness of the meetings in terms of helping with the stressful experience of being on an acute ward and three of the NP group mentioned the value of either talking or being listened to. This is shown in Table 2.4.

Sub-dimensions	Number of clients expressing discourse in each dimension: P Group	NP Group	Sample Quotations
Helping to discuss difficult environment	2	-	P4: *"because I was isolated in hospital, and was surrounded by people with different kinds of illnesses. Some sort of chronic. It was nice to have somebody to talk about that sort of environment with."*
Importance of talking/being listened to	-	3	NP2: *"Its important for me to have a contact like T2. Because she's a listener. Someone there to listen to the problems I've got."*

Table 2.4. Sub-category 1B: Client's descriptions of progress in non-specific terms.

Category 2: Being able to move clearly to new interpretations while disregarding old ones. One of the central criteria for progression in therapy, highlighted by the therapists, was a changed interpretation. Considering the quotations relating to this issue in particular suggests that such changed interpretations had two components. The first of these was a new understanding. However, as mentioned above, three members of the NP group did appear to have such a new understanding in the sense that they were already able to describe an illness model of their symptoms. This suggests that the second component of a changed interpretation is the ability to move on from an old understanding. This category emerged from an apparent contrast between the groups in this second aspect of change. The code had two sub-categories.

2A. Ability to move on from a distressing interpretation.

2B. Inability to move on from a distressing interpretation.

The dimensions of therapists' discourse in sub-category 2A are summarised in Table 2.5. It can be seen from this table that the descriptions of all four of the P group included instances of one explanation supplanting another (in each case lowering distress). No such discourse was found in the descriptions of the NP group.

Sub-dimensions	Number of clients mentioned by <u>therapists</u> in each dimension		Sample Quotations
	P Group	NP Group	
Explanation being eliminated by logical challenge	1	-	<u>T1 on P1</u>: *"we were able within the five months that I saw him to construct an experiment which was good enough... We figured out what it would mean to him if it went either way, in which he attempted to communicate something to the deputy manager of the house by telepathy who reported back to P1 that he'd heard nothing, didn't know what P1 was thinking. And then P1 was instantly convinced that telepathy was not happening."*
One explanation superseding another	2	-	<u>T2 on P2</u>: *"when I first started to see him which was of a kind of vaguely supernatural explanation. It was something to do with evil and the devil, maybe God somehow engineering these things. And he's ended up with I suppose more of an illness model."*
Understanding inhibiting psychotic experience	1	-	<u>T3 on P3</u>: *"Getting a different perspective on the periods of illness has helped her have that insight and I think its the insight that's helping her keep well."*

Table 2.5. Sub-category 2A: Therapist's discourse on ability to move on from a distressing understanding.

The idea that those in the P group were able to disregard or move on from more distressing understandings also emerged from the discourse of the clients in this group. This is reported in Table 2.6 below.

In sub-category 2B (inability to move beyond distressing understanding) therapist descriptions of three clients in the NP group suggested that these clients were *failing* to move beyond distressing explanations despite also possessing interpretations which might appear to preclude these explanations. (See Table 2.7).

Sub-dimensions	Number of clients expressing discourse in each dimension: P Group	NP Group	Sample Quotations
One explanation superseding two others	1	-	P1: *"I thought [the voices] might be people in the world. But since T1s come I think maybe its just a trick of the mind more than telepathy. I also thought it might be Satan. Satan or telepathy. The original two explanations."*
Eliminating other explanations	1	-	*P1: "by a process of ... elimination... I eliminated Satan and said it was telepathy and... I thought it was a trick of the mind."*
Use of external evidence to disprove psychotic thoughts	1	-	P3: *"what I really needed to do was have this check list of facts that disproved elements in my false memories that I can always, if I'm in doubt, I can always run through."*
Putting boundaries round other explanations	1	-	P3: *"I feel as if I've really put the boundaries round those false thoughts and I feel as if I've got them in a nice little corner locked away now."*

Table 2.6. Sub-category 2A: Client's discourse suggesting moving on from a distressing understanding.

Sub-dimensions	Number of clients mentioned by therapists in each dimension: P Group	NP Group	Sample Quotations
Holding two explanations similtaneously	-	2	T1 on NP1: *"he's quite happy with this twin track explanation that what the problem is that he has a mental illness and there are evil spirits attacking him."*
Sliding into other multiple explanations	-	2	T2 on NP2: *"he didn't have one kind of, or even two, definitive explanations for his experiences... There's this kind of whole range of possible explanations and any attempt to sort of pin them down was really completely unsuccessful. He'd slide off into another explanation."*
New knowledge failing to eliminate earlier interpretation	-	1	T2 on NP2: "*He would sometimes hear what seemed to be his brother [Sammy's[4]] voice saying 'they're going to kill me'... He would phone Sammy to, check that he was OK, and Sammy would say "What are you going on about, I'm fine". So NP2 would think to himself well maybe there's another Sammy in a parallel universe.*

Table 2.7. Sub-category 2B: Therapists discourse on inability to move on from a distressing understanding

[4] Not his real name.

Therapists' descriptions of NP clients' seeming failure to move from or disregard distressing understandings were supported by the discourse of the clients in the NP group. The sub-dimensions and quotes from three members of the NP group are shown in Table 2.8.

Sub-dimensions	Number of clients expressing discourse in each dimension: P Group	NP Group	Sample Quotations
Contrasting statements during interview	-	2	NP1: *"The voices are just the same... But no they've got quieter. Sometimes I can barely hear them at all... But I'm in agony."* NP3: *"I talk in my room to the IRA... when I'm fairly psychotic I do things because of my mind."*
In vivo alternative realties	-	1	NP2: *"I witness somebody killing somebody else and I told her about this. And I gave the identity of each person but I said I dunno why I told this. It seems too silly to go to the police and say I witnessed a murder and so on by so and so. I told my previous doctor about my dad's problem. His approach was much, much more serious that I ever thought it would be. It seems that my dad's a doctor in a way."*
No control over engaging with psychotic thoughts	-	1	NP3: *"I became mentally ill a long time ago ... and I began to have these sorts of visions... but I just can't help talking about these things [dialogue with imaginary IRA men] you know."*

Table 2.8. Sub-category 2B: Clients discourse suggesting inability to move on from a distressing understanding.

The quotations in Tables 2.7 and 2.8 suggest a number of different ways in which NP clients are failing to disregard distressing understandings. The therapist's description of NP1 implies that this client was capable of holding views which appeared contradictory for P group clients without feeling they *were* contradictory (e.g. a supernatural model and an illness model). This apparent tolerance of contradiction appeared to be supported in the

interview with NP1 who made a number of conflicting remarks about his mental state. NP3 (who had a fairly detailed illness model to explain his symptoms) described a lack of control in becoming involved in his belief system. The therapists description of NP2 suggested a fluid movement between different sets of psychotic beliefs or views of reality which were not controllable. This was borne out in the sessions when NP2 apparently moved between different views of reality during the interview.

Category 3: Ability to engage in thinking logically or reflectively. This code referred to therapist discourse on the importance of the clarity of clients' thinking in making progress in therapy. The views of therapists are supported by illustrations of clear and unclear thinking in client discourse. There were two sub-categories in this code:

3A. Ability to think reflectively.

3B. Inability to reflect adequately.

Examples of therapists discourse relating to sub-category 3A are given in Table 2.9. All discourse suggesting clearly reflective or logical thinking applied to clients in the P group and no descriptions of equivalent clarity of thinking were provided in discourse about the NP group. As well as the value of clarity of thought, two of the therapists talked about the value of them being able to help the client think clearly a capacity which did not appear in descriptions of the NP group. T3 also signalled the value of P3 thinking about her own thought processes (a form of meta-cognition). A sense of this ability to think about thinking is also indicated by P3's quote about putting "boundaries round false thoughts" in Table 2.4.

Sub-dimensions	Number of clients mentioned by <u>therapists</u> in each dimension: P Group	NP Group	Sample Quotations
Using therapist to aid clarity of thought	2	-	<u>T1 on P1:</u> *"And yet there was a sense in which the way I was there was almost as a kind of cognitive prosthesis. That I was doing the thinking for him and he could attach my thinking to his thinking and that's kind of as far as it went."*
Clear thinking aiding understanding	1	-	<u>T2 on P2:</u> *"at times when his thinking is clearer he can also understand it in terms of a kind of stress/vulnerability interaction."*
Thinking about thinking (meta-cognition)	1	-	<u>T3 on P3:</u> *"Certainly I think she's [now] got good insight and is able to engage in thinking about how she thinks about things and try to change that."*

Table 2.9. Sub-category 3A: Therapists' discourse on ability to think reflectively.

The sub-category 3B on inability to think reflectively applied only to NP clients. This in this sub-category is reported in Table 2.10.

Sub-dimensions	Number of clients mentioned by <u>therapists</u> in each dimension: P Group	NP Group	Sample Quotations
Inability to think clearly enough	-	1	<u>T1 on NP1:</u> *"He just doesn't seem to reflect very well."*
Inability to think logically enough	-	1	<u>T2 on NP2:</u> *"Reflecting on your experiences for cognitive therapy requires some capacity to kind of think through things at kind of semi-logical level anyway. Or at least to follow someone else doing that. And I just really didn't think NP2 could do that. It was almost like the more we focused on his psychotic experiences the harder it got for him to think about them."*

Table 2.10. Sub-category 3B: Therapists discourse on inability to think reflectively.

The description of clearer thought processes in the P group contrasted with two of the therapist's descriptions of clients in the NP group. The description offered by T2 appears to be supported by the quote in Table 2.8 from NP2 where the logic of thought processes

is difficult to discern. A further example of an exchange from the interview with NP2 may also serve to illustrate the lack of observable clarity in his thought processes.

> "Interviewer: What kind of reasons, can you give me an example of a reason [for the experiences].
> NP2: I mean in terms them being part of the crime syndicate, people on the street people out there. If they know something about it. For instance the people who shot my dad, killed my dad.[5] Where, why... Its just the first time I've experienced it. You see a piece in the newspaper 'So and so was killed by', or 'a dead body was found by' and that's all you see but what you think to yourself in terms of your analysis or interpretation of the event is my god, it could be that he was trying to cash in his insurance...They give you status, status."

Such speech is highly disordered with little logical sequence. The implications of this type of difficulty for CBT with psychosis are taken up in the Discussion.

Category 4: Continuity in therapy. This code described therapists' discourse concerning the ability of clients to work on therapy with a measure of continuity from session to session. This category is intended to reflect the clients ability or willingness to hold a representation of the therapy over time from. The sub-categories were:

4A. Showing continuity in therapy. (See Table 2.11).

4B. Absence of continuity. (See Table 2.12).

	Number of clients mentioned by <u>therapists</u> in each dimension		
Sub-dimensions	**P Group**	**NP Group**	**Sample Quotations**
Continuity in therapy	3	-	<u>T1 on P1:</u> *"He remembered things I was saying and considered them between times."* <u>T3 on P3:</u> *"We picked up themes and worked on them over time."*

Table 2.11. Sub-category 4A: Therapists discourse on continuity in therapy.

[5] His father was alive at the time of interview.

Sub-dimensions	Number of clients mentioned by <u>therapists</u> in each dimension: P Group	NP Group	Sample Quotations
Absence of continuity	-	2	<u>T1 on NP1:</u> *"It was always my experience that he would change his tune. Simply forgetting something that was blatantly obvious in the previous session. And it's almost as if every session is new ground."* <u>T4 on NP4:</u> *"So different things would come out in different sessions and we would try and tackle these. And then we'd try to tackle an earlier one and she'd go 'oh no, no it's not really a problem any more.'"*
Discontinuity in clients experiential world	-	1	<u>T2 on NP2:</u> *"Its only relatively recently after a year and a half of working with him that he thinks I might come back. Previously he thought that a missed session was me gone. And would be really quite shocked when I returned."*

Table 2.12. Sub-category 4B: Therapists discourse on absence of continuity in therapy.

The descriptions of the two client groups clearly contrast in this category. Three of the clients in the P group showed an ability to work on themes over a period of a number of weeks in therapy. Two of the clients in the NP group the were described in completely opposite terms as being unable or unwilling to work in this way. A more severe difficulty emerged from T2's description of NP2 which suggests that such continuity was initially extremely difficult because the client could not maintain the idea that she [the therapist] was a permanent object who would return.

Category 5: Remembering and understanding therapy. The previous category describing ability or willingness to work on themes from session to session appeared to be supported by the ability or willingness of clients to describe and elaborate on elements of their therapeutic work *after* therapy was complete. Like the previous category this one is related to ability to hold a representation of the therapy, though in this case over a longer

time period as all therapies had been completed for a minimum of four weeks at the time of interview. This category emerged from the discourse of clients when talking about specific elements of the therapy or in describing changes resulting from interventions. As with the previous main categories there were two sub-categories:

5A. Being able to clearly remember and understand therapy. This rated by the ability to describe specific techniques or being able to describe how interventions helped or changes occurred.

5B. Less clear memory and understanding of therapy. This was rated using discourse suggesting a failure to remember specific techniques or being unable to describe interventions.

The dimensions of clients discourse in category 5A is summarised in Table 2.13.

	Number of clients expressing discourse in each dimension		
Sub-dimensions	**P Group**	**NP Group**	**Sample Quotations**
Remembering a specific suggestion	3	2	P2: *"Tried to read books, watch TV to stop the voices you know."* NP3: *"At one point we were looking at me going to a social club."*
Operationalising a change	3	-	P3: *"I feel I have a terrible problem with not being able to motivate myself to get things done. And she suggested to me that maybe it was because my standards for myself were too high and that had never occurred to me."* P4: *"I do have the option of looking at a situation and changing my perception."*

Table 2.13. Sub-category 5A: Clients discourse showing clear remembering and understanding therapy.

It can be seen in Table 2.13 that three of the clients in the P group were able to give descriptions of particular suggestions made by the therapist. However, two of the clients in the NP group were also able to do this. A clearer distinction between groups was observed when it came to describing *how* they had been helped. Three clients in this group

were able to operationalise the change clearly (i.e. say what it was and how it worked) rather than just saying that the therapy or elements of it were helpful in an unspecified way.

The failure to operalationalise the idea of "helpful" formed a sub-dimension of sub-category 5B "less clear memory and understanding of therapy" (See Table 2.14). Such failures to provide meaningful descriptions of change were a feature of the discourse of two of the NP group. As can also be seen in Table 2.14 three of the NP clients appeared to sometimes find it difficult to remember therapist suggestions, something which did not feature in the P group.

	Number of clients with discourse in each dimension		
Sub-dimensions	**P Group**	**NP Group**	**Sample Quotations**
Failing to remember specific suggestions	-	2	NP1: *"He'd give me suggestions but I can't remember, can't remember."* NP3: *"I dunno if she's suggested any ways in which I could be helped."*
Failing to operationalise the idea of helpful	-	3	NP1: *"NP1: [A book on voices] was a certain way beneficial* *I: Could you tell me how it helped?* *NP1: It was helpful, helpful."*

Table 2.14. Sub-category 5B: Clients discourse showing less clear memory and understanding of therapy.

Category 6: Therapeutic alliance- shared goal. The "trust" and "confidence" dimensions of therapeutic alliance did not appear to highlight differences between the two groups. In relation to direct questions about trusting or having confidence in the therapist, all clients answered positively. Therapists suggested that there were limits to the trust and confidence of clients in both groups. It was therefore difficult to draw any clear conclusions as to differences in these dimensions of therapeutic alliance between P and NP clients. However, considering the matter of shared goal in therapy, there was some suggestion (in therapist discourse particularly) that there was a difference between the two

groups of clients in terms of sense of a shared task. Once again discourse was classified into two sub categories:

6A. Shared task clearly observable. (See Table 2.15).

6B. Shared task not clear. (See Tables 2.16 and 2.17).

	Number of clients mentioned by therapists in each dimension		
Sub-dimensions	**P Group**	**NP Group**	**Sample Quotations**
Clear description of shared task	3	1	T1 on P1: *"He never volunteered much but nonetheless he walked the walk. You know it was clear that he was thinking things in between times and he knew why I was there and roughly the focus of what we were doing and why I was asking those questions."* T3 on NP3: *"I think, though we have an explicit shared task which is working on the thoughts that bother him."*

Table 2.15. Sub-category 6A: Therapists discourse on clear shared task in therapy.

It can be seen from Table 2.15 that, with three of the P group, therapists were able to state that they felt there was a clear shared task. T3 also said she felt that she had a shared task with NP3. However, as can be seen from Table 2.16 (below) she also described a second major therapeutic task which was not being shared with him. Table 2.16 also shows circumstances where therapists felt that there was less sense of shared task with clients (all of whom were from the NP group) and, in the case of NP2, the impossibility of truly sharing the real work of therapy with a client with an extremely complex psychotic illness.

Sub-dimensions	Number of clients mentioned by therapists in each dimension		Sample Quotations
	P Group	NP Group	
No sense of shared task	-	2	T1 on NP1: *"I felt that NP1 was, despite my continued asking of him of what he wanted to do with these sessions, I felt that he was talking the talk... it wasn't necessarily an alliance in that sort of mutual sense that both of us knew that there was work to do."* T4 on NP4: *"I think she did things because she felt they were the polite thing to do."*
Difficulty of sharing task with client	-	1	T2 on NP2: *"I think with NP2 it's more difficult because the... task is really rebuilding him, his sense of himself and therefore other people. And if someone already has fundamental difficulties in those areas its pretty hard to actually say explicitly that that's what you think the work is."*
All therapy tasks not being shared	-	1	T3 on NP3: *"I also have a goal that perhaps isn't necessarily shared which is to look at the broader context of how he sees things and how his beliefs have developed. And see if there's any way of trying to shift that."*

Table 2.16. Sub-category 6B: Therapists discourse on shared task not being present.

The suggestion that a shared task was not always present in the NP3 group was borne out by the discourse of two of the clients from that group. This is reproduced in Table 2.17. It can be seen that NP2 appeared to signal that he had a different agenda in therapy which perhaps was not being addressed. NP4 described how the therapist had become incorporated at points into her delusional system (as an agent of the IRA whom she felt were persecuting her). Such an incorporation would imply a fundamental breakdown in having a shared task or agenda.

Sub-dimensions	Number of clients with discourse in each dimension: P Group	NP Group	Sample Quotations
Client has different agenda	-	1	NP3: *"I: Are you focused on the same stuff or is she going different ways from you? NP3: Well this is where I feel that my therapy could take a new direction... I feel. It could be that my therapy needs to be taken much more seriously."*
Therapist becoming incorporated into the delusional system of the client	-	3	NP4: *"But then I thought that maybe she was only pretending to phone the police and that maybe she was involved in the IRA as well."*

Table 2.17. Sub-category 6B: Client's discourse indicating shared task not present.

Central Theme: Understanding, Holding and Engaging with the Therapist's Model of Reality

The process of selective coding is intended to focus on the central theme emerging from the results. The clearest theme emerging from the six categories described was a pronounced difference in understanding, holding and engaging with the model of reality offered by the therapist between clients who progressed in CBT and those who did not progress.

This theme initially emerged out of the "definitions of progress" category. Therapists defined all of the P group as having changed their interpretation of a symptom or acquired a different understanding leading to reduced distress. Though therapy clearly had benefits out with this cognitive definition of progress, this kind of change appeared central in the whole notion of progressing in CBT.

Completely engaging with the therapist's model of reality appears to be contingent on leaving more distressing explanations behind. NP4, for example, had an illness model of her difficulties which, while not a pleasant thought, was less disturbing than her delusional system (involving persecution by the IRA). Progression also appeared to be contingent on a clarity or reflectiveness of thought required by the therapy. For example, NP2 appeared to have extremely disorganised thought processes, making such tasks difficult. Possessing such reflective capacity appeared to be one of the mechanisms by which people could shift *and* one of the possible goals of therapy (as in the examples where clients can use the therapist to support their thinking). This touches on a larger issue of whether the all differences between the two groups observed were present during the therapy as part of the process, or something which developed as part of the therapeutic outcome. This matter is taken up in the Discussion.

The fourth and fifth categories of continuity and remembering and understanding related to the *holding* element of this theme. Both the degree of holding during therapy (e.g. from week to week) and the quality of holding (e.g. being able to actually describe how a change occurred and why) distinguished the P and NP groups. The notion of a shared goal as part of therapeutic alliance also seemed to be a fundamental aspect of *engaging* with the therapist's reality. The P group appeared engaged in the task of therapy (ultimately set by the therapist) whereas the NP group either would not or could not engage quite so fully.

The Results of the Inter-Rater Reliability Study

An independent rater was asked to perform three tasks involving classification of the quotations used in the six main categories. All of these quotations were drawn from the

quotation set reproduced in Appendix 7. The instructions given to the rater are reproduced in Appendix 11. The three tasks were as follows:

1. *Main category inter-rater reliability (IRR).* In the first task the rater was asked to classify 15 sample quotations under the six main category headings without prior knowledge of the categories to which the quotes had been assigned to by the author. To aid this process they were given brief descriptions of the categories.
2. *Sub-category IRR.* In the second task the rater was given the title of each category and a brief description. They were given sets of quotations assigned to each main category by the author (these quotations comprised approximately 70% of the quotations reproduced in Appendix 7). They were then provided with the titles of the two sub-categories of each main category and asked to classify the quotations according to these sub-headings (again without knowledge of the sub-categories already assigned by the author).
3. *Sub-dimension IRR.* In the third task the rater was once again given the category titles, definitions and the quotations assigned to the categories used in the second task. On this occasion the rater was asked to classify the quotations according to lists of sub-dimensions provided (once again without knowledge of prior classification).

Inter-rater reliability was calculated using Cohen's Kappa (κ). This calculates a measure of concordance corrected for chance variations among raters. Tables showing numbers of cases used to generate each κ statistic and significance levels are given in Appendix 11. κ values are interpreted according to the classification of strength of agreement provided by Landis and Koch (1977). The κ value for the main IRR task was 0.68. (equalling "substantial" strength of agreement in the Landis and Koch classification). Areas of disagreement between the rater and the author were confined to allocation of quotations to

either Category 1 or Category 2 which used a number of the same quotations. κ values for the sub-category and sub-dimension IRR tasks are reproduced in Table 2.18.

Main Categories	κ for task 1 (Sub-category coding) and strength of agreement	κ for task 2 (Sub-dimension coding) and strength of agreement
1. Definitions of progress	0.71 (substantial)	0.85 (almost perfect)
2. Being able to move clearly to new interpretations while disregarding old ones.	1 (perfect)	0.67 (substantial)
3. Ability to engage in thinking logically or reflectively	0.72 (substantial)	1 (perfect)
4. Continuity in therapy	1 (perfect)	1 (perfect)
5. Remembering and understanding therapy	1 (perfect)	1 (perfect)
6. Therapeutic alliance-shared goal	0.7 (substantial)	1 (perfect)

Table 2.18. κ values signalling inter-rater reliability for sub-category and sub-dimension IRR tasks.

As can be seen above, κ values ranged from substantial to perfect indicating excellent inter-rater reliability.

The Results of the Respondent Validity Study

Three of the original participants were re-interviewed between six and eight weeks after the original interviews, and asked to give their views on the category scheme. One participant was drawn from each of the three groups (T2, P3 and NP3). The schedules for these interviews are given in Appendix 12, along with a brief discussion of the considerations raised by the sharing of the coding scheme with the client participants. The therapist was asked to rate the six main categories produced as distinguishing between people who progress and do not progress in CBT for psychosis using a five point Likert scale (from 1 "strongly disagree" to 5, "strongly agree"). The clients used the same scale to rate the importance of the categories from their own experience. Where appropriate NP3 was asked if particular areas (such as letting go psychotic thoughts) were difficult.

The ratings produced a high level of agreement with the categories produced in the analysis. T2 rated her agreement as either 4 or 5, that each of the categories distinguished between progressors and non-progressors in this kind of therapy. P3 also rated her agreement as 4 or 5 with all of the main categories as applying to her. NP3 similarly rated his agreement as 4 or 5 with all areas being important and rated his agreement as 5 with the suggestion that was difficult to move forward from his psychotic understandings.

Confirming his comments in the main study (see Table 2.8) he said:

> *"Yes that's important. Sometimes its just too difficult to stop them and I end up in my room having these thoughts."*

Discussion

Main Findings

The central question posed in this research related to observable differences in accounts of the therapies of individuals who progressed or failed to progress in CBT for psychosis. The categories described in Results suggest that there are indeed such differences in the therapies of these two groups. The first main difference between the them was in outcomes (as defined by the therapist) with the P (progressor) group appearing to have changed their understandings of their symptoms and be experiencing less distress associated with those symptoms, whereas the NP (non-progressor) showed no evidence of having done so. Clearly, this is a product of the selection process. As therapists selected clients on the basis of whether or not they had progressed in CBT terms it was highly likely that those individuals classed in the P group would have improved in the areas described. This finding also suggests that the therapists concerned had clear and homogeneous ideas of what progress in this therapy means. The sense of improvement was supported by the P client group, three of whom spoke favourably about CBT related improvements. There did appear to be benefits of therapeutic contact outside of strictly CBT criteria. Therapists and clients in both groups outlined a number of non-therapy specific areas, including the benefits of regular contact with a therapist and of talking and having concerns heard.

The second major area of difference between the groups concerned a disregarding of psychotic understandings of symptoms. While the NP group appeared to have accepted other understandings of their symptoms (such as illness models), they still had psychotic

interpretations (such as being persecuted by the IRA). The P group on the other hand appeared to be able to *replace* the psychotic understanding with another understanding (such as voices being a trick of the mind). The ability to think reflectively also emerged as a discriminator between the two groups; though for some of the clients in the P group this appeared to occur by using the therapist as an aid to help clear and logical thinking. A sub-dimension of the ability to think reflectively was the ability to think about ones own thought processes, often termed meta-cognition.

The two groups were also different in terms of their ability to hold a representation of the therapy. This occurred both from week to week (in therapists' accounts) and in terms of remembering and understanding the therapy (in clients' accounts). Therapists broadly said that continuity from week to week was more prevalent in the P group. Clients in the P group and the NP group appeared both to be able to remember specific elements of the therapy. However, clients NP group were less able than those in the P group to actually say how techniques had been helpful and how changes had occurred.

Finally, the results suggested that there was a difference between the groups in terms of developing a shared goal in the therapy. Though direct questions of clients as to the presence of a shared goal usually elicited agreement that there was such a goal, therapists expressed the views that they either were unable to develop a truly shared agenda or that there were elements of their agenda which were difficult to share.

The results reflect a comparative failure of the members of the NP group to understand, hold and engage in therapy relative to the P group. Broadly, the NP group appeared less

able to enter into the frame of reference provided by the therapy. Clearly the idea of engagement with a different frame of reference, or a different model of reality, implies that therapy is providing an alternative view that a client must engage with if progress is to be made. This implication is discussed further in the section below on the overall theme.

Before proceeding, however, it is worth considering the implications of the results outlined relative to the preceding literature on CBT for psychosis.

General Implications

The findings of the present study support the general tenor of the outcome studies of CBT described in the introduction. Clearly the method employed in the present study provided no information on the proportion of recipients of this kind of therapy who improved or the comparative success rates of CBT compared to different therapies. However, it is clear that those participants who were selected as having improved appeared to manifest the kinds of changes described by Chadwick and Lowe (1990), Fowler and Morely (1989) and Watts et al. (1973) in that they were all described in terms of changed interpretations of symptomatology. To refer back to the quotation from Slater and Roth (1969) reproduced on page 1, it did seem once again that reasoning with clients was a far from futile process for some individuals.

Consideration of the perspective of clients has (with the exception of some surveys carried out in the London/East Anglia RCT which showed high satisfaction levels; Kuipers et al., 1997), been absent from the CBT literature in this area. Therefore it was also of importance in the present study that these judgements of success by therapists were not one-sided. Three of the clients classed as having progressed were able to clearly describe

their progress in terms consonant with the therapists' descriptions and appeared to experience changes in interpretation or perspective as helpful. The other P client (P2) was, it must be noted, less clear on this point. This client was experiencing a high level of disturbance and his therapist (T2) did express some doubts as to the maintenance of the effects of therapy after completion. It is possible the he was already having difficulty holding some of the understandings which (according to the therapist) had developed in the therapy.

The present study also showed broadly positive views of therapeutic contact more generally from both progressors and non-progressors. Members of both groups described beneficial elements of therapy not unique to CBT. This suggests that clients' responses the therapy (and the therapists) were broadly favourable whether or not they improved in CBT terms. However, observations of positive clients responses, while important, must be treated with caution however as a result of the participant selection process. It is perhaps unlikely that therapists would select clients whom they suspected were going to be negative or hostile about the therapy. It is not known whether any of the clients who declined to participate (therapist's reports suggested three in total, all classed as non-progressors) had such negative perceptions. The participation of such clients might have led to a different picture.

The non-specific benefits of the therapy (also mentioned by the therapists) supports the observation in two recent RCTs (Sensky et al., 2000 and Tarrier et al., 1998) suggesting that more generally supportive interventions do appear to have a beneficial effect for some individuals. In the present study it appeared that non-specific benefits can occur whether

or not someone is able to benefit from CBT. It is also possible that some of the non-specific gains mentioned (such as T2s description of enhancing the NP2's perception of the reality and permanence of the world around him) would be extremely difficult to access or measure in a large-scale study using established questionnaires. An advantage of the present methodology which concentrated individual accounts appears better suited to accessing such benefits.

A further area in which the results of the present study relate closely to the published literature is in the area of factors which appear to predict progress in therapy. Chadwick and Lowe (1990) suggested that the ability to question delusional beliefs through reaction to a hypothetical contradiction is a possible predictor of success in treatment. On a similar theme, Garety et al. (1997) found that willingness to entertain the possibility that psychotic beliefs might not be true (as suggested by the MADS item "When you think about it now is it at all possible that you are mistaken about X?") was the central predictor of a successful outcome in CBT. The observation that those classed as non-progressors in the present study had difficulty *disregarding* distressing psychotic beliefs (rather than just entertaining other potentially, distressing beliefs) appears related to both of these predictive variables. P group clients in the present study appeared to respond to genuine contradictions and actual evidence that they were mistaken with belief change. NP clients on the other hand appeared to either be comfortable with holding beliefs that would seem contradictory to others, or to be unable to halt an engagement with psychotic versions of reality. It is worth noting that Garety et al. (1997) suggested that those people who could contemplate alternatives might progress in CBT. However, the present study appears to indicate that a slightly different emphasis might be important: namely that in CBT, as well

as contemplating alternatives, it literally is the realisation of being *mistaken* and a concomitant letting go of the psychotic belief that is important.

The issue of logical or reflective thinking may also relate to the predictive variables suggested by Chadwick and Lowe (1994) and by Garety et al. (1997). One way to define clarity of thinking might be to suggest that someone is able to perceive the contradictory nature of two apparently opposed beliefs. By this standard the NP group were less logical in terms of their thinking. However it is also important to note that none of the outcome studies have found any measures of logical or reflective thinking to be related to outcome. For example the London/East-Anglia trial employed measures of IQ and reasoning biases (cf. Garety and Hemsley, 1994) and found that neither was associated with outcome in CBT.

If measures of logical thinking do not predict outcome this contrasts with the apparent importance of logical or reflective thinking in the present study. The issue of how logical thought relates to progress signalled two important limitations of the present findings. Firstly, within this study the definitions given of logical or reflective thought are far from precise and it is possible that therapists were talking about something different from the kinds of factors measured by the main outcome trials.

Secondly, there is the issue (already signalled in the Results) that the development of logical thought may be something that actually emerges during therapy rather than being a capacity present at the beginning. It may not be possible to predict at the beginning of

therapy who will be able to think clearly enough to progress. As T2 commented in the Respondent Validity Study (Appendix 12):

> "I think it [logical thinking] probably does distinguish them but it may not be apparent at the beginning that some peoples' thought can become clear enough to engage properly."

The suggestion in the present study was that some P group individuals whose thinking was neither logical nor reflective enough to challenge any aspect of their condition, were able to utilise the therapists' thinking processes to enhance there own. The issue of how far the findings of this study indicate abilities which can predict progress from therapy is discussed further in the Critical Review section below.

One area emerging from the study where pre-existing logical thinking capacities might make CBT extremely difficult may be the presence of thought disorder. This symptom has been characterised by Andreason (1979) as "a pattern of spontaneous speech in which the idea's slip off track onto another that is clearly but obliquely related or onto one that is completely unrelated" (p. 1315). Because the inference of disordered thought must be made primarily from disorganised speech, other authors (APA, 1994; Bentall, 1990) have termed this condition speech disorder. Though one of the main positive symptoms in a diagnosis of schizophrenia thought disorder does appear to have been somewhat disregarded in the development of CBT for psychosis. Participant NP2 provided a graphic insight into the difficulties that someone with thought disorder (as demonstrated by his disorganised and, at times, somewhat bizarre speech) could apparently pose for a therapist when trying to work in this way. With this client it was very difficult to delineate a

coherent belief about the nature of reality to challenge within a CBT framework, or even at times to make him believe that the therapist was a permanent part of a stable reality.

The issue of "holding of therapy" does not find any reference in the CBT psychosis literature. It is logical, however, that those who are able to hold the themes of therapy over the weeks may be more likely to progress (or perhaps that progression may lead to greater understanding). The remembering and particularly the understanding of therapy also appeared to distinguish between the P and NP group. Once again it is not possible to ascertain whether a capacity to understand was something which distinguished the groups at the beginning of therapy or whether this was something which emerged during the therapy.

The finding that there may not always be a shared goal in the case of non-progressors is a novel one in this field. None of the main outcome studies in this area have investigated the association between any aspect of therapeutic alliance and outcome. However, a meta-analysis of the research literature on therapeutic alliance and outcome in a range of therapies by Hovarth and Symonds (1991) suggested that up to 30 percent of variability in outcomes for psychological therapies could be accounted for by quality of therapeutic alliance. It is unsurprising therefore that this factor emerged from the present study. In view of the comparative neglect of therapeutic alliance in this area thus far it would be desirable to attempt to replicate this finding (see Suggestions for Future Research). It is also clear that the maintenance of therapeutic alliance may also have clinical implications (see below).

Clinical Implications

One of the tests of the validity of qualitative research methodologies outlined in the Method section was the applicability of the findings. The results of the present study suggest a number of areas of relevance to the clinical practice of CBT with psychosis. These appear to apply to two areas in particular: how change is achieved and how success rates might be improved (where the results raise some important questions).

In terms of how change is achieved (or not achieved), the accounts of the therapeutic process in this study provide an enhanced picture of what goes on in this kind of therapy. Taking the issue of moving on from distressing understandings as an example, the implication of the literature to this point has been that new understandings are central to success. However, the present study emphasises the need for work in understanding and changing existing distressing understandings.

The issue of logic or reflexivity in thinking is also one of central salience and particularly the notion that the therapist can act to almost "scaffold" the thinking of clients who are not capable of clear enough thought by themselves. Many therapists would be sensitive to the issue of the holding of therapy which appears to be a clear marker of the potential outcome of therapies. The issue of therapeutic alliance may be a difficult one to address with hostile or suspicious clients who have psychotic beliefs; however again it appears important in successful therapies. Though many therapists are already aware of these issues, the present study does emphasise the centrality for CBT work of trying not merely to offer alternative interpretations and see if a client can accept them, but a broader picture of

moving clients from one view towards the consistent holding of another, less distressing view.

The results also make the important point that the non-specific effects of therapy may be very valuable to clients. In the absence of clear shifts in interpretations from clients, the importance of the therapy may be easily underrated. An interesting example of this came from NP4, who was grateful for the contact she had had with T4 and wished to see a psychologist again. T4 however felt that NP4 had not progressed at all, and did not mention any non-specific benefits. At the end of the therapy T4 had been extremely surprised to receive a home-made present and a card from the client.

While the present study goes some way towards providing a picture of *what* happens in CBT and of important elements in change, asking how success rates might be improved raises two important questions: *why* some people find it so difficult to shift and *how* to achieve change with such individuals? Two of the therapists interviewed (T2 and T3) described various issues which they felt were relevant to helping clients who appear unable to move. For example, T3 suggested that NP3 might have a powerful emotional investment in the beliefs he held and that this impeded progress. This kind of argument appears related to that put forward by Bentall, Kinderman and Kaney (1994) that delusions (particularly persecutory delusions) can protect an individual's self-esteem. As noted in the Introduction, the evidence for low self-esteem among people with persecutory delusions is mixed. Freeman et al. (1998) have suggested that low self-esteem may be manifest in a number of different types of delusions. It is possible that, rather than being implicated in all persecutory delusions *per se*, emotional issues such as self-esteem may

only be relevant for a subset of people. It may be that individuals who do have these emotional difficulties may find it more difficult to move away from psychotic explanations in therapy. Such a conclusion would require future research (see below).

Other possible explanations for failure to progress in CBT may revolve around thinking difficulties. For example, the presence of the kind of abnormal reasoning biases described by Garety and Hemsley (1994) might be implicated in difficulties shifting from an implausible belief. However, the London/East-Anglia trial did not show that a measure of reasoning biases was related to success in therapy. The thinking difficulties apparently shown by clients such as NP2 may also be implicated in the difficulty some (though on the basis of this study, clearly not all) people have in changing beliefs.

A third explanation for difficulty in shifting from distressing understandings may concern the role of information processing in psychosis. Hemsley (1994) in particular has pointed to the role of inadequate focused attention in regulating the contents of consciousness and the failure to eliminate non-salient stimuli, both internal and external. He has argued that the capturing of attention by material that would ordinarily be ignored ends up with the material being attributed false significance. Making sense of these intrusions may result in delusional beliefs. This is a simplified outline of Hemsley's model and there is a vast amount of evidence relating to impaired attentional focus in psychosis which cannot be reviewed here. However, in a general sense this type of explanation may offer a way forward in thinking specifically about individuals who do not progress in CBT. It may for example be that non-progressors are perhaps more severely impaired in terms of information processing capacities (such as those Hemsley has discussed) and this might be

a barrier to progress. Predictions of emerging from such a possibility would be highly testable via the use of information processing tasks before and during therapy.

It is clear that considering *how* to tackle apparent difficulties in making therapeutic shifts in CBT will benefit from a clearer understanding of the reasons why such shifts are difficult. Clearly there does not have to be a single reason. A combination of the kinds of explanations outlined above is possible.

Overall Thematic Framework

As discussed above, the overall theme of understanding, holding and engaging with a therapy was proposed to link the categories emerging from the analysis. The various ways in which clients appeared to engage or failed to engage have already been discussed. However, the question might reasonably be put of how, in cognitive therapy engagement with the therapists' frame of reference appears so central. After all, this therapy is broadly collaborative exercise with an emphasis on shared effort. I wish to put the argument that, despite this collaboration and the emphasis on individuals making up their own minds about interpretation, accepting the therapist's version of symptoms is ultimately one of the fundamental features of CBT.

Of course in some ways all therapies ask clients to view emotions or experiences from a different perspective. In psychoanalytic work, for example, a therapist may try to facilitate a change in interpretation of a painful emotion from something which must be defended against to something which can be worked through. However, viewing experience from a different perspective appears to be a particular feature of CBT. To take work with

psychosis as an example: the stages of therapy outlined by Fowler et al (1995), though they started with coping strategy work, are then predominantly focused on changing meanings of and beliefs about symptomatology and about the self. In line with this, each of the therapists in the present study identified changed interpretations as a crucial component of success in CBT. Meaningful progress in CBT for psychosis would therefore appear to revolve around accepting changed interpretations provided by the therapist: an alternative reality for people with psychosis. Therapist and client can collaborate in tasks to test out the evidence for particular beliefs about reality. However, unless this collaboration leads to a sharing of beliefs between therapist and client the success of therapy appears unlikely to be classed as more than a partial success.

Suggestions for Future Research

The Clinical Implications section suggests a number of areas for further research. Emotional factors which may be involved in psychotic belief maintenance, the possible role of thinking or reasoning deficits, and the role of information processing factors might all be related to a failure to shift. Replication of the main distinguishing categories themselves, particularly in view of the small sample would also be of benefit. This particularly applies to the finding on the shared goal aspect of therapeutic alliance which has not hitherto been investigated in this type of therapy.

Given the number of possible explanations for failure to progress in therapy one possible area for development of the current study was the range of psychotic symptoms considered in the sample. For example, the study did not concentrate solely on delusions or one type of delusions, but on delusions and hallucinations of various types. This was

partly due to the limited availability of participants. Clearly, however, a more precise focus on particular symptoms and subsets of symptoms (such as persecutory delusions) might have advantages in pinpointing issues and points of impasse which may be unique to particular groups.

A final area where there may be need for further research is to investigate the possibility that some of the distinguishing features of the groups (such as capability for logical thinking or ability to maintain continuity in therapy) may have some *predictive* power in terms of outcome. As discussed in the following section, the retrospective nature of the interviews makes assuming any predictive power of these factors impossible.

Critical Review

Though the study did help to develop a clearer understanding of some of the factors distinguishing progressing and non-progressing therapies, a number of limitations of have already been signalled in the preceding discussion. For example the selection procedures for the clients may limit the conclusions that can be drawn as to clients attitudes to the therapy. There is also the issue, highlighted in Clinical Implications, of why some clients find it more difficult to engage with the model of reality put forward by the therapist and how to change this. However, increased clarity about what is happening in non-progressing therapies is a necessary first step in the consideration the process of why this happens and how to change it.

Perhaps the main limitation of the methodology was a result of the retrospective nature of the interviews. Though a number of potentially important dimensions in therapy emerged

from respondents' discourse it was impossible to decide on the basis of this data set whether they were the result of capacity differences predating therapy, factors that emerged in the process of therapy or factors which only emerged at the end or in retrospect. This clearly limited the predictive power of the study. It is clear that further research trying to measure some of the distinguishing variables pre-therapy would be required if they were to be proposed as predictors of success.

A further limitation of the present methodology, and a criticism often made of qualitative research concerns the small sample of individuals considered and resulting concerns over the generalisability of the findings. However this must be set against the richness and depth of the data which can emerge from detailed consideration of such a small group of people. Like single case research, qualitative methodologies can form part of a broader picture producing, as this study has, ideas which can be investigated further using larger samples and different methodologies.

Finally it is perhaps worth mentioning one possible consequence of the study: namely the effect, particularly in the ongoing therapies, of the clients and therapists discussing the therapy with an outsider. The interview methodology chosen introduced a forum in which to reflect on the progress of the therapy and the changes made. Though the possible effects of this were not addressed in the main interviews or the respondent validity study, several of the participants (both therapists and clients) suggested that the issues which arose in the interviews were making them "think again" about elements of the therapy and future directions. The effects of this thinking again are unknown. However, it might be instructive to revisit this issue with some of the participants at a later date.

Conclusions

It is clear that the study has pinpointed a number of differences between individuals who progress in CBT for psychotic problems and those who do not. These occur in a variety of areas, including ability to move on from psychotic beliefs, logical thinking capacities, holding and understanding therapeutic themes in terms of a therapeutic alliance characterised by a shared goal. Overall individuals who progressed in CBT appeared to have a greater understanding and holding of the model of reality proposed by the therapist and a greater engagement with the therapeutic framework and the therapist.

It is clear that judgements of success in therapy were broadly shared by both clients and therapists. Also, even when individuals failed to progress in CBT terms both therapists and clients indicated that there were other benefits emerging from therapeutic contact.

These results do appear to fit with previous investigations of CBT particularly with reference to studies which suggest that that improvement may be predicted by willingness to accept the possibility of being mistaken and others which show positive effects of non specific factors out with CBT. Further research appears to be required as to the role of logical thinking, engagement and therapeutic alliance in treatment success.

The picture which emerges of people with different outcomes in CBT signals a number of important issues for clinical practitioners. However, the crucial question of why some people are able to progress and some are not is one which does require further investigation.

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Research Ethics Committee

CONSENT FORM FOR PARTICIPATION IN RESEARCH PROJECTS & CLINICAL TRIALS

Title of Project:
A consideration of patients and therapists experiences of psychological therapy

Principal Investigator: Dr. John McGowan **Other Investigator/s** **enrolling patients:** Prof. Philippa Garety	**Ethics Committee** **Code No:**

Outline explanation:
In this study you are invited to take part in an investigation looking at peoples experiences of psychological therapy. At the present time an increasing number of people are having psychological therapies to help them with a range of difficulties. It is important therefore that psychologists consider how effective these kinds of therapies are effective and look at some of the reasons why they work or don't work. In this study both psychotherapists and people who have received therapy will be interviewed and asked for their thoughts on the therapy.

We would like to ask you to come along for a short, confidential interview (usually at the place where you had the therapy). This will take approximately 45 minutes and will involve a range of questions about how you experienced the therapy. With your permission we would like to record each interview on audio tape. We would also like your permission to interview the therapist whom you saw and ask them a few questions about how they feel you progressed. These interviews will also be audio taped.

The recordings will be confidential and only the investigators and two other psychologists (see following paragraph) will have access to them. The recordings of each interview will be transcribed by the investigators. All information which could identify you or the therapist will be removed during transcription. At the end of the study all the audio recordings will be erased. If you wish we can give you a copy of the tape of your own interview to keep.

The information from the interviews will provide the basis of a report on peoples experiences of psychological therapy. Once again all information which could identify particular individuals will be removed from the report. The report will be submitted as part of the first investigator's Clinical Psychology doctorate. The two psychologists who examine the report might request to listen to some of the audio tapes before they are erased. They will be the only people other than the investigators who can hear the recordings. They will be required to show sufficient reason for listening to any of the tapes and will be required to treat what the hear as strictly confidential. The report may also be submitted for publication in professional journals read by psychologists and psychiatrists. The publicising of the findings in this way means that you could have a real impact on psychological treatments in the future.

I (name) _____

of (address) _____

_____

hereby consent to take part in the above investigation, the nature and purpose of which have been explained to me. Any questions I wished to ask have been answered to my satisfaction. I understand that I may withdraw from the investigation at any stage without necessarily giving a reason for doing so and that this will in no way affect the care I receive as a patient

SIGNED (Volunteer) _____ **Date** _____

(Witness) _____ **Date** _____

The two parallel interview forms are designed to elicit reflections on a variety of stages of the process of psychotherapy. Patient participants will be asked to answer from their experience of their personal therapy. Therapist participants will be asked answer relative to the two clients they have suggested for the study. The interview questions are initially broad in theme, becoming more specific over the course of the interview. Individual questions may also be followed by more specific prompts.

Parallel form 1: Interview Schedule for Patient Participants

1. Tell me about your therapy.

2. Can you give me some idea of the circumstances which led you to the therapy sessions with X (therapists name)?
Possible prompts
- Can you give me a clearer idea as to your experiences?
- Were these experiences difficult for you or for others?

3. What did you expect from the therapy sessions?
Possible prompts
- What did you want from the sessions?
- What was your understanding of their purpose?

4. Were the therapy, and the therapist, what you expected?
Possible prompts
- In what ways was it similar to or different from your expectations?

5. Overall what were the things which you found helpful about the therapy?

6. Overall what were the things you found less helpful about the therapy?

7. What were your experiences with the therapist like?
Possible Prompts
- Was this someone you had confidence in?
- Was this someone you felt you could trust?
- Did you feel that you were working towards the same ends?
- What elements of this relationship were helpful/unhelpful?

8. What kinds of suggestions did the therapist make?
Possible Prompts
- Did the therapist ask you to think or do specific things?
- What was the purpose of these from your point of view?
- Were these helpful/unhelpful to you?

9. How are you now?
Possible Prompts
- In your mind?
- Have there been changes which you think are because of the therapy?

Parallel form 2: Interview Schedule for Therapist Participants

1. Tell me about the therapy with X?

2. Can you give me some idea of the circumstances which led X and X (clients names) to therapy?
Possible prompts
- Can you give me a clearer idea as to their experiences?
- Were these experiences difficult or problematic for them or others?

3. What kind of expectations do you feel were set up for the therapy sessions?
Possible prompts
- What did they want from the sessions?
- How did you explain their purpose?

4. Do you feel the therapy conformed to the client's expectations?
Possible prompts
- In what ways was it similar to or different from their expectations?

5. Overall what your perception of the things each client found helpful about the therapy?

6. Overall what your perception of the things each client found less helpful about the therapy?

7. How did you feel your relationship and alliance with the client developed?
Possible Prompts
- Were the clients able to feel confidence in you?
- Did they seem to be able to trust you?
- Was there as sense of shared tasks between you and each of these clients?
- What elements of the therapeutic relationship were helpful/unhelpful?

8. What kinds of therapeutic techniques or tools did you employ?
Possible Prompts?
- What was the intended purpose of these?
- Were these helpful/unhelpful?

9. How is the client now?
Possible Prompts
- Mentally?
- Have there been changes which you think result from the therapy?

Clinical Psychology Training
Salomons Centre, Broomhill Road
Southborough
Tunbridge Wells
TN3 OTG

Dear

Factors implicated in the outcome of cognitive behavioural treatments for psychotic problems

Thank you for your correspondence dated 6.1.00 and for submitting a revised consent form and addressing the queries raised by the Research Ethics Committee. This is satisfactory and I am happy for the study to commence.

Please note that this project carries a reference number, noted above, which must be quoted in any future correspondence.

The project number and the principal investigator must be clearly stated on the consent form. If approval is given to named investigators only, these names must also be stated on the form.

In the case of research on patients, a copy of the consent form must be placed in the patient's medical records, together with a note of the date of commencement of his/her participation in the research. A label must appear on the outside cover of the records when the patient is participating in the research.

The investigators must adhere to the published Guidelines of the Committee and provide the Chairman with annual progress reports and an end of study report. The research should start within 12 months of the date of approval.

The LREC is compliant with the ICH GCP requirements.

Yours sincerely

Chairman
Research Ethics Committee

Encl.

NHS

Clinical Psychologist in Training
Salomons Centre, Broomhill Road
Southborough
Tunbridge Wells
TN3 0TG

Dear

Protocol: **Factors implicated in the outcomes of cognitive behavioural treatments for psychotic problems**

Our Ref: *(please quote in all correspondence)*

This study has been approved by Chairman's action and further endorsed by another Committee member, under reciprocal arrangements made with

Yours sincerely

Chairman

Clinical Psychology Training
Salomons Centre, Broomhill Road
Southborough
Tunbridge Wells TN3 0TG

Dear

Re: Factors implicated in the outcome of Cognitive Behavioural Therapy for psychotic problems

The Ethical Committee (Research) considered and gave local approval to the above study at its meeting on 18 February 2000.

Initial approval is given for one year. This will be extended automatically only on completion of annual progress reports on the study when requested by the EC(R). Please note that as Principal Investigator you are responsible for ensuring these reports are sent to us.

Please note that projects which have not commenced within two years of original approval must be re-submitted to the EC(R).

Please let me know if you would like to nominate a specific contact person for future correspondence about this study.

Any serious adverse events which occur in connection with this study should be reported to the Committee using the attached form.

Please quote Study No. in all future correspondence.

Yours sincerely,

Research Ethics Coordinator

Dear X,

My name is Dr. John McGowan and I am a Clinical Psychologist in Training. I am writing to you following contact you have recently had from XX (therapist's name). XX has suggested to me that you might be willing to participate in a research study I am conducting looking at people's experiences of psychological therapies.

I understand that you have completed a number of sessions of this sort of therapy with XX. I would be very interested in hearing about your experience of these sessions. Details of the project and the interviews are provided in the enclosed information sheet. I also wish to interview XX (therapists name) about their experiences of the sessions with you. Please be assured that the interviews will be in strict confidence.

As someone who has used mental health services I am very interested in hearing your experiences and I very much hope that after reading the enclosed information that you will be able to participate in the study. I will call within the next few days once you have had the chance to read the enclosed information sheet.

The Study is based at and I can be contacted via the Regional clinical Psychology Training Scheme at the Salomons Centre (see address above). If you have any questions require further explanation of any aspect of the project please get in touch with me via Salomons on 01892-507667.

I look forward to hearing from you.

Yours sincerely

Dr. John McGowan
(Clinical Psychologist in Training)

Research Study on Experiences of Psychological Therapy

Investigators:

Dr. John McGowan,
South East Thames
Clinical Psychology Training
Salomons Centre,
Broomhill Rd.,
Southborough
Tunbridge Wells,
KENT TN3 0TG.
01892-507667

Prof. Philippa Garety,
Dept. of Academic Clinical Psychology
Riddell House,
St. Thomas' Hospital
London SE1 7EH.

What is the study about?
At the present time an increasing number of people are having psychological therapies to help them with a range of difficulties. It is important therefore that psychologists consider how effective these kinds of therapies are effective and look at some of the reasons why they work or don't work. In this study both psychotherapists and people who have received therapy will be interviewed and asked for their thoughts on the therapy. We are particularly keen to have your views as someone who has used services in this way.

What do I have to do?
We would like to ask you to come along for a short, confidential interview (usually at the place where you had the therapy). This will take approximately 40 minutes and will involve a range of questions about how you experienced the therapy. With your permission we would like to record each interview on audio tape. We also wish to interview the therapist whom you saw and ask them a few questions about how they feel you progressed. These interviews will also be audio taped.

What will happen to the recordings?
The record of each interview will be transcribed by the investigators. All information which could identify you or the therapist will be removed during transcription. The recordings will be confidential and only the investigators in the project and people involved in assessing it (see following paragraph) will have access to them. At the end of the study all audio recordings will be erased. If you wish we can however give you a copy of the tape of your own interview to keep.

What happens then?
The information from the interviews will provide the basis of a report on peoples experiences of psychological therapy. Once again all information which could identify particular individuals will be removed from the report. The report will be submitted as part of the first investigator's Clinical Psychology doctorate. The report may also be submitted for publication in professional journals read by psychologists and psychiatrists. The publicising of the findings in this way means that your views could have a real impact on psychological treatments in the future.

Do I have to sign anything?
If you are interested in participating in the study we would like you to sign a short consent form saying that you are willing to participate and giving us permission to talk with your therapist about how you go on in therapy. Please understand that even after signing this form you are free to withdraw from the study at any time.

Anything else?
We are able to pay your travel expenses to the interview. If you are interested in participating in the study or just require further information please contact Dr. John McGowan (details given above).

Field Notes: Participant P2

Described myself as "freaked out". felt utterly powerless to engage him and ran through my questions in about 10-12 minutes with no control. Strong feeling of having screwed up completely and feeling of hopelessness vis research and that I would have to throw away this interview. A sense in which he was actively disengaging on a range of fronts. No obvious affect but restless, moving and going out of the room on two occasions. Also speed, indistinctiveness and brevity of answers.

Discussion with Tony to clarify some of these feelings. Immense power of my response suggests literally freaked "out" with me carrying much of a feeling of hopelessness in him. The fragmentation of his personality perhaps too much for therapy. The sense of what it was like does come across in the transcript but some of him was projected into me which could itself be a valuable source of data.

Axial Coding Memos

Memo 1. Definitions of progress
This category encompasses the judgement of progress. This is primarily from the judgement of therapists though quotations from clients are also used. There are two sub-categories. A. Success for inclusion in the study and B. Other more non-CBT specific improvements. Important as it shows how people changed.

A. Therapists have already made an implicit judgement by selecting these people. This is about operationalising this judgement. Not all of them do it explicitly. Therapists are judging the process of clients according to whether they feel they have progressed or not progressed in terms judged as CBT. Broadly the criteria for success here are based around changed thinking. This implies some sort of CBT criteria out with questionnaire measures. All those who changed in this was were in the success group. With the NP group 100% in NP definitions. This is unsurprising due to the selection process. However it is important in that it suggests some homogeneity in the P and NP groups in CBT terms. This provides a firm basis to go on and discuss why they fell into these groups.

Therapist quotations and dimensions:
Therapists on Progressors

T1 on P1: "P1 was instantly convinced that telepathy was not happening and therefore also doubted that Satan was behind it" **Changed interpretation of symptom**

"Felt empowered to do things about the voices in terms of simple behavioural ways of blocking and so on which he hadn't dared try before". **Changed means of dealing with symptom**

"Says he is relieved and is happy" **Reduced distress relative to symptom**

T2 on P2: "when I first started to see him which was of a kind of vaguely supernatural explanation. It was something to do with evil and the devil, maybe God somehow engineering these things. And he's ended up with I suppose more of an illness model. That its something to do with his brain not quite working in the way it should and his mind plays tricks on him." **Changed interpretation of symptom**

"So I suppose I was defining success really in terms of a shift in P1's understanding of his difficulties." **Changed interpretation of symptom**

"thinking about success in terms of, success as it might be understood in a CBT model because that's what you seem to be asking about... although he still seems to be distressed by these experiences he's less distressed than he was. He seems to have more of an understanding of what these experiences are. More of an understanding that is less frightening to him." **Reduced distress relative to symptom**

T3 on P3: "Certainly she has some blips in her mood depending on what's going on externally. But sort of seems to manage that really well." **Managing mood variations**

"she's doing the kinds of practical things that she needs to be doing." **Practical improvements**

"Getting a different perspective on the periods of illness has helped her have that insight and I think its the insight that's helping her keep well." **Changed interpretation helpful**

"I think its the insight that's helping her keep well. That's kind of she doesn't feel in that situation that people sometimes do when they're well. That they could fall into this kind of gaping chasm of illness again. If feel like she's explored the chasm a bit. Put a few lanterns down there, that kind of thing. She understands it a bit more and therapy's probably helped her do that." **Understanding helping to prevent relapse**

T4 on P4: "She did see that she'd got stressed and strung out and she'd got highly stressed so she was happy to take medication for that." **Changed means of dealing with symptoms**

"We talked a little bit about 'when your on the lookout for things'. So... you know if you believe people are following you you're much more likely be suspicious and looking out for things when you're hyper-vigilant then you're more likely to find things. So we talked a little bit about that. And she again had quite a lot of insight." **Changed interpretation of symptom**

Progressors

P1: "I: Can you tell me about seeing T1 for therapy?
P1: I like him. I think he's very helpful. He's helped me understand the voices more." **Help from increased understanding**

"I prefer the new explanation [its] less frightening than Satan. Satan's the devil isn't he. A trick of the mind doesn't seem so frightening" **Reduced distress relative to symptom**

P3: "I wanted to be able to find a way of dealing with the problem of sorting out for myself what was really about my memories and what was false about them. And T3 has helped me do that." **Successful problem solving**

P4: "She... was helping me to change my thought patterns to perhaps perceive something in a different way. In a more positive as opposed to a negative way...They were quite useful interviews " **Changed perspective helpful**

Therapists on non progressors

T1 on NP1: "I don't think I really was able to engage him.. in the way I might have liked to have worked i.e. in a kind of CBT way." **No CBT engagement**

NP1 feels that things are improved against how things were a year ago. I have to say I don't know how convinced I am about that". **Therapist does not feel there is improvement**

T2 on NP2: "If its in terms of the CBT approach then my work with NP2 has been unsuccessful because he has not been able to consider, systematically consider, other ways of looking at his psychotic experiences and understandings." **No change of interpretation**

T3: on NP3: "We haven't managed to change how he sees it." **No change of interpretation of symptoms**

T4 on NP4: "I didn't really get anywhere with NP4." **Therapist does not feel there is improvement**

"she was 60% sure it was the IRA, 40% it was schizophrenia. She did think that she probably was ill but that the illness affected her concentration and memory. But in the end it was still the IRA." **No change of interpretation of symptoms**

None of the NP clients commented on this area.

B. The next area of judgement of success is in ways non-specific to CBT. Not involving changed understandings or behaviour. A feature of this sub-category was that therapists included NPs in it.

Therapists on P clients

T1 on P1: "P1's expectations were simply that I would turn up and he felt that was useful." **Usefulness of turning up**

T3 on P3: "I think that having her psychotic experiences taken very seriously might have been quite therapeutic." **Usefulness of taking experiences seriously**

T4 on P4: "at least she had the experience of no having someone say 'you're deluded, go away'." **Usefulness of taking experiences seriously**

Progressors

P3: "I was going through the experience of being on an acute ward and I think T3 was having to listen to a lot of how I felt about that. Because it's quite stressful, especially if you're very depressed and your surrounded by very manic people." **Helping to discuss difficult environment**

P4: "because I was isolated in hospital, and was surrounded by people with different kinds of illnesses. Some sort of chronic it was nice to have somebody to talk about that sort of environment with." **Helping to discuss difficult environment**

Therapists on non-progressors

T1 on NP1: "I was helping him by being an intelligent person who'd have a chat with him." **Providing social contact**

T2 on NP2: " but it is seemingly successful in other ways... if it becomes possible for him to feel more certain about my reality and my role for him that it may also be possible therefore to see other people in those terms which then opens up possibilities." **Ability to see other people as real and permanent**

T3 on NP3: "It has been successful in the sense that he's engaged and he's talked about it and that he carries on coming which is a good thing." **Continued engagement useful**

T4 on NP4: Did not see non-cog aspects as useful though client appeared to.

Non-progressors

NP2: Its important for me to have a contact like T2. Because she's a listener. Someone there to listen to the problems I've got." **Importance of talking/being listened to**

NP3: "I think just to discuss it and get it off my chest is helpful." **Importance of talking/being listened to**

NP4: "I'd seen counsellors before and I expected a sympathetic ear." **Importance of being heard**

"I could talk about my problems as they arose. I was seeing her every week. Every week I had different problems. I could talk to her about them." **Importance of talking/being listened to**

Memo 2. Being able to move clearly to new interpretations while disregarding old

This category refers to the ability of the changed understandings (which were part of the criteria for success) to preclude other understandings. This is greater than inability to change understanding which was part of the first code. One new understanding (of the type required for success in CBT) seems to leave the other state behind. This is a discriminant category as all Ps seem to be able to make this jump while NPs don't seem to be able. This also relates to the fact that illness understandings did not discriminate between the two groups. The key thing seems to be what you *do* with the illness understanding. i.e. use it to preclude another understanding. There are two sub-categories therefore. A. Ability to gain a changed understanding and shift to another state and stay there and B. Inability to use one state to preclude another.

A. Based on the scripts from the Ps this suggests that most of these people could shift from one understanding to another and not go back. Many of these quotes are the same or overlap with those from the changed understanding/success section.

Therapists on progressors

T1 on P1: "we were able within the five months that I saw him to construct an experiment which was good enough....It was totally flawed logically as a scientific experiment but he was able to carry this out and it was convincing for him. We figured out what it would mean to him if it went either way, in which he attempted to communicate something to the deputy manager of the house by telepathy who reported back to P1 that he'd heard nothing, didn't know what P1 was thinking. And then P1 was instantly convinced that telepathy was not happening." **Explanation being eliminated by logical challenge**

"I said, 'It is was really telepathy could medication make a difference?' and he said 'well in couldn't', and he said 'so I'm thinking perhaps your right." **One explanation superseding another**

T2 on P2: "when I first started to see him which was of a kind of vaguely supernatural explanation. It was something to do with evil and the devil, maybe God somehow engineering these things. And he's ended up with I suppose more of an illness model." **One explanation superseding another**

T3 on P3: "Getting a different perspective on the periods of illness has helped her have that insight and I think its the insight that's helping her keep well." **Understanding inhibiting psychotic experience**

T4 on P4: "I got her to reinterpret a bit within a model of stress-vulnerability which she did take on board" **One explanation superseding another**

Progressors

P1: "I thought [the voices] might be people in the world. But since P1s come I think maybe its just a trick of the mind more than telepathy. I also thought it might be Satan. Satan or telepathy. The original two explanations." **One explanation superseding two others**

"by a process of ... elimination... I eliminated Satan and said it was telepathy and the I thought it was a trick of the mind." **Eliminating other explanations**

P2: Nothing from this one

P3: "what I really needed to do was have this check list of facts that disproved elements in my false memories that I can always, if I'm in doubt, I can always run through." **Using external evidence to disprove psychotic thoughts**

"I feel as if I've really put the boundaries round those false thoughts and I feel as if I've got them in a nice little corner locked away now." **Putting boundaries round other explanations**

Therapists on non progressors

T1 on NP1: "NP1 also took a very psychiatric view of what was the matter with him saying , "I have a mental illness" and like a lot of people with these kinds of beliefs he's quite happy with this twin track explanation that what the problem is that he has a mental illness and there are evil spirits attacking him." **Holding two interpretations simultaneously**

"But in the end he felt no this is probably some sort of mental illness full stop and probably evil spirits as well full stop." **Holding two interpretations simultaneously**

T2 on NP2: "I think that's part of the problem in terms of doing cognitive therapy with someone like T"; he didn't have one kind of, or even two, definitive explanations for his experiences. He kind of had a range... There's this kind of whole range of possible explanations and any attempt to sort of pin them down was really completely unsuccessful. He'd slide off into another explanation." **Sliding into other explanations**

"He would sometimes hear what seemed to be his brother [Sammy's] voice saying 'they're going to kill me'... He would phone Sammy to, check that he was OK, and Sammy would say "What are you going on about, I'm fine". So NP2 would think to himself well maybe there's another Sammy in a parallel universe. **New knowledge failing to eliminate earlier interpretation**

T3 on NP3: Nothing clear here

T4 on NP4: she was 60% sure it was the IRA, 40% it was schizophrenia." **Holding two interpretations simultaneously**

"you sometimes got some glimpses of insight... and 'it would be good if it was schizophrenia because it would mean these things wouldn't be true even though I would be very sad about it' you would get these glimpses and they would slip away and she would be off in lipspeak and the IRA." **Sliding into other explanations**

Non progressors

NP1: "The voices are just the same...But no they've got quieter. Sometimes I can barely hear them at all... But I'm in agony." **Contradictory statements during the interview**

NP2: "I witness somebody killing somebody else and I told her about this. And I gave the identity of each person but I said I dunno why I told this. It seems too silly to go to the police and say I witnessed a murder and so on by so and so. I told my previous doctor about my dad's problem. His approach was much, much more serious that I ever thought it would be. It seems that my dad's a doctor in a way. **In vivo alternative reality**

"last Saturday I went out and went to the cash point up the road. I saw somebody who looked like my brother there. He looked exactly like him. Caught a train to Catford, saw another person who looked like my brother there. I caught the bus from Catford to Lewisham and again there was another bloke who looked like my brother there. Everywhere, he's everywhere. Who is it?" **In vivo alternative reality**

NP3: "I became mentally ill a long time ago ... and I began to have these sorts of visions... but I just can't help talking about these things [dialogue with imaginary IRA men] you know." **No control over engaging with psychotic thoughts**

"When I talk in my room about the IRA...when I'm fairly psychotic I do things because of my mind." **Contradictory statements during the interview**

Memo 3. Ability to engage in thinking logically or reflectively.

This refers to the clients ability to think clearly and logically during (and as a result of therapy). It is possible that all people with psychosis a lack of clarity in this respect experience this to a degree. However there is an extent to which therapy may have helped them do this. Also interesting here is the use of the therapist to scaffold thinking processes (which appears to be absent in the NP group).This category involves two sub-categories. A. Ability to think clearly (including using elements of the therapy to do so) and B. Inability to reflect.

A. Ability to think reflectively.

T1 on P1: "And yet there was a sense in which the way I was there was almost as a kind of cognitive prosthesis. That I was doing the thinking for him and he could attach my thinking to his thinking and that's kind of as far as it went." **Using the therapist to aid clarity of thought**

T2 on P2: "at times when his thinking is clearer he can also understand it in terms of a kind of stress/vulnerability interaction." **Clear thinking aiding understanding**

"I think there's something in the consistency of regular weekly therapeutic sessions with someone who could hold the information that he'd given last week and put it together with this week so there was some kind of continuity in his story that he couldn't necessarily maintain independently." **Using the therapist to aid clarity of thought**

"You're helping him to think about his thinking. And reflecting that back to him and making it at accessible to him." **Using therapist to aid clarity of thinking**

T3 on P3: "Certainly I think she's [now] got good insight and is able to engage in thinking about how she thinks about things and try to change that." **Thinking about thinking affording possibility of change**

T4 on P4: Nothing

B. Inability to think reflect. This starts to dip into thought disorder.

T1 on NP1: "He simply doesn't seem to reflect very well" **Inability to think clearly enough**

T2 on NP2: "Reflecting on your experiences for cognitive therapy requires some capacity to kind of think through things at kind of semi-logical level anyway. Or at least to follow someone else doing that. And I just really didn't think NP2 could do that. It was almost like the more we focused on his psychotic experiences the harder it got for him to think about them." **Inability to think logically enough**

T3 on NP3: Nothing

T4 on NP4: Nothing

NP2: "I: What kind of reasons, can you give me an example of a reason [for the experiences]. NP2: I mean in terms them being part of the crime syndicate, people on the street people out there. If they know something about it. For instance the people who shot my dad,

killed my dad* . Where, why... Its just the first time I've experienced it. You see a piece in the newspaper 'So and so was killed by', or 'a dead body was found by'and that's all you see but what you think to yourself in terms or your analysis or interpretation of the event is my god, it could be that he was trying to cash in his insurance...They give you status, status." **Thought disordered discourse**

* His father is still alive.

Memo 4. Continuity in therapy

This refers to the ability to work with themes with some continuity (which the therapists described and the retrospective holding of techniques (which comes from the client interviews). Holding continuous themes. Ps and NPs both discussed. A process variable which may be either a product of the mental state that precludes them from engaging from therapy or a consequence of other factors which have stopped engagement leading to little memory holding between sessions.

A. Continuity

T1 on P1: "He remembered things I was saying and considered them between times." **Continuity in therapy**

T2 on P2: Nothing

T3 on P3: "We've picked up themes and worked on them over time." **Continuity in therapy**

P4 on P4: "She was engaged and we would discuss the same themes over the weeks." **Continuity in therapy**

B. Absence of continuity

T1 on NP1: "It was always my experience that he would change his tune. Simply forgetting something that was blatantly obvious in the previous session. And its almost as if every session is new ground." **Absence of continuity**

T2 on NP2: "Its only relatively recently after a year and a half of working with him that he thinks I might come back. Previously he thought that a missed session was me gone. And would be really quite shocked when I returned." **Discontinuity in clients experiential world**

T3 on NP3: Nothing

T4 on NP4: So different things would come out in different sessions and we would try and tackle these. And then we'd try to tackle an earlier one and she'd go 'oh no, no its not really a problem any more.' **Absence of continuity**

Memo 5. Remembering and understanding therapy.

This continuity point leads to another related point about memory of therapy. This comes from the clients discourse. The two groups are distinguished their memory of specific elements of therapy *retrospectively*. Members of both groups can remember some but the "can't remember" phrase appears much more widespread for the NP group. All the things remembered mesh with therapist suggestions. Like the previous variable this may be a product of mental state preventing engagement or a result of having not engaged.

A. Being able to clearly remember and understand therapy. This may consist of either remembering specific techniques or being able to describe change.

One therapist quote also seems to capture this

(T1 on P1: [At the end] I think there's hardly any detail of the cognitive work I tried to do with NP1 that he could reiterate to me. **Client failing to remember therapy)**

P1: "He introduced me to the voice monitoring sheet... Its a daily record of how the voices work". **Remembering a specific suggestion**

"He said 'Tell them to go away, don't let them rule you', T1 said that." **Remembering a specific suggestion**

"I eliminated Satan and said it was telepathy and then I thought it was a trick of the mind." **Operationalising a change**

P2: "Tried to read books, watch TV to stop the voices you know... to block [the voices] out." **Remembering a specific suggestions**

"I: What kind of suggestions did she make?
"Wear headphones, cover ears, that sort of thing" **Remembering a specific suggestion**

P3: "We're looking at strategies and ways I can change my patterns of thinking. You know, all the things that everybody has where the continually trip up over the same obstacles." **Operationalising an understanding that is helpful**

"I feel I have a terrible problem with no being able to motivate myself to get things done. And she suggested to me that maybe it was because my standards for myself were too high and that had never occurred to me." **Remembering a specific suggestion**

P4: "to perhaps think about what this person was saying and to think about how I interpreted what they said. And she asked me to write down the next time something like that happened." **Remembering specific suggestion**

"I do have the option of looking at a situation and changing my perception" **Operationalising a change**

NP1: "I'm not supposed to try and stop the voices coming. He [the therapist] told me to ignore it". **Remembering a specific suggestion**

NP3: "At one point we were looking at me going to a social club." **Remembering a specific suggestion**

B. Less clear memory and understanding of therapy. Not operationalising things that were apparently helpful. No understanding purpose of techniques or not being able to remember techniques. All of these quotations are from non progressors.

NP1: "He'd give me suggestions but I can't remember, can't remember." **Failing to remember specific suggestions**

"NP1: [A book on voices] was a certain way beneficial
I: could you tell me how it helped?
It was helpful, helpful." **Failing to operationalise helpful**

NP2: "I: What kinds of things have been helpful about what she's been doing?
NP2: Helping me to be more sensible about the voices. Talking it through"
I: How Is that helpful?
NP2: I dunno if its helpful. It tends to be verbal diarrhoea coming from me."
Failing to operationalise helpful

NP3: "I dunno if she's suggested any ways in which I could be helped" **Failing to remember specific suggestions**

NP4: "We talked about cars and said that whenever you think you expect to see red cars sort of thing. So variety is what you expect to see or something. I can't quite remember."
Partially remembering a therapist suggestion

"I think most of the things I found helpful I can't remember." **Failing to remember specific suggestions/ Failing to operationalise helpful**

Memo 6. Aspects of therapeutic alliance

The notions of trust and confidence in therapeutic alliance do not appear to be discriminant. Both Ps and NPs show limits to trust and confidence and some of both were able to operationalise trust. However shared task does seem to discriminate between the two groups. Two dimensions here once again. A. Shared task clear from both sides; B. Shared task not in evidence from both sides. Once again this could be a process or an outcome variable (i.e. it could be observed during therapy or something that comes out of a successful therapy at the end).

A. Shared task clear

T1 on P1: "He never volunteered much but nonetheless he walked the walk. You know it was clear that he was thinking things in between times and he knew why I was there and roughly the focus of what we were doing and why I was asking those questions." **Clear description of shared task**

T2 on P2: "[Shared task] clear enough to know what we were doing" **Clear description of shared task**

T3 on P3: "I: Has there been a sense of shared task.
T3: I think so yes. I get that sense with P3. We try to negotiate goals and whatever. I mean goals in terms of outcome and goals in terms of process as well. "what are we going to talk about for the next few sessions", "How do you feel this is going" and that kind of thing. Yeah I feel there's that." **Reality of shared task**

T4 on P4: Nothing

T3 on NP3: "I think, though we have an explicit shared task which is working on the thoughts that bother him." **Clear description of shared task**

All clients answered in the affirmative to the question "do you think you have the same goals" except NP2 (see below) even when expectations were completely different.

B. Shared task not clear.

T1 on NP1: "I felt that NP1 was, despite my continued asking of him of what he wanted to do with these sessions, I felt that he was talking the talk... it wasn't necessarily an alliance in that sort of mutual sense that both of us knew that there was work to do." **No sense of shared task**

T2 on NP2: "I think with NP2 its more difficult because the... task is really rebuilding him, his sense of himself and therefore other people. And if someone already has fundamental difficulties in those areas its pretty hard to actually say explicitly that that's what you think the work is." **Difficulty of sharing task with client**

T3 on NP3: "Shared task. Well I suppose its a little bit different with him. Because... I also have a goal that perhaps isn't necessarily shared which is to look at the broader context of how he sees things and how his beliefs have developed. And see if there's any way of trying to shift that... I mean its certainly shared in the context of talking about it because its within the context of making sense of the conversations and I think that its a shared goal to that extent." **All therapy tasks not being shared**

T4 on NP4: "I think she did things because she felt they were the polite thing to do." **No sense of shared task**

NP2: "I: Are you focused on the same stuff or is she going different ways from you?
Well this is where I feel that my therapy could take a new direction because One reason sometimes when I feel. It could be that my therapy needs to be taken much more seriously." **Different agenda from therapist**

NP4: "But then I thought that maybe she was only pretending to phone the police [laughs] and that maybe she was involved in the IRA as well." **Therapist becoming incorporated into the delusional system of the client**

Memo for Overall Theme

Memo: Understanding, holding and engaging with the therapist model of reality

This overall category is intended to encapsulate the overall theme of the data

This theme initially emerges out of the "definitions of success". Therapists defined all of the P group as having changed their interpretation of a symptom or acquired a different understanding. Though therapy clearly had benefits even if this particularly cognitive step was not achieved it appeared central in the whole notion of progressing in CBT. So it is clear here that, perhaps as in all cognitive therapy, taking on board the world view of the therapist (and the therapy) is central to success.

The categories which appear to discriminate between the two appear to flesh out this failure to understand and hold the therapist's version of reality. While it appears to be possible to engage up to a point in alternative explanations for psychotic phenomena (in this context less distressing understandings) it appears more difficult for some people to leave more distressing explanations behind. I was particularly struck by NP4 in this respect as she wished to believe her difficulties were the result of schizophrenia but was unable to disentangle her self from the fear of persecution by the IRA. The idea of bridging into another reality emerges here. Some people can throw a bridge to another reality whereas others cannot.

The notion of clarity of reflection or thinking appears to fit here as clients are being asked to think in a way set by the therapy in order to progress. It involves a coherence of beliefs and an ability to distinguish them from the alternative agenda proposed by the therapist. Such reflective capacity appears to be one of the mechanisms by which someone can shift *and* one of the possible gaols of therapy (as in the examples where clients can use the therapist to scaffold their thinking.

The fourth and fifth categories of continuity and remembering and understanding both relate to the *holding* element of this theme. Once again these elements can be related to progress (holding during therapy) or outcome (holding after therapy). Both the degree of holding (e.g. the repeated "I can't remember") the quality of holding (e.g. being able to actually describe how a change occurred and why) are relevant here.

The notion of shared goal as part of therapeutic alliance also seems to be a fundamental aspect of *engaging* with the therapists reality. It seems that understanding and holding are pre-requisites for this. However then the question seems to be "can the person engage sufficiently". As on of the therapists in the respondent validity study pointed out, this can also be something that occurs during the process or something that is happens towards the end. However it does seem important.

What sums this theme up is seemingly an ability to enter the world (or the frame of reference) of the therapist while sufficiently disengaging from the psychotic frame of reference. In all elements it appears that some people can do it during the therapy, some more towards the end, and some not at all.

Research Diary

May 27th 1999

Have decided to go ahead with a project on CBT with psychosis. The initial idea is to explore perceptions of CBT as experienced by psychologists who practice it and by clients who have done either well or badly in this type of treatment. I hope to tease out some of the factors in therapy which occur in good or poor outcomes. To generate as broad a range of possibilities I wish to use a qualitative methodology and interview the participants. Tony suggests a "grounded theory" methodology as an appropriate tool for theory generation. I guess that one of the limitations of previous work in this area is that it has only considered what people have included in advance in the trial (e.g. measures of therapeutic alliance). This is kind of doing it the other way round: looking at the finished article and trying to work out what was important.

Unfortunately I think that talking to clients and therapists who have been part of the same dyads may create to many practical difficulties. Pity as would have been interesting to triangulate the method in this way and get their reflections of the "same" process.

Talked to Phillipa Garety today and she has agreed to supervise me. She raised several difficulties. Most particularly the problem of getting clients (particularly those clients who had not succeeded in therapy) to reflect on the therapeutic process. This is related to some implicit hypotheses I have. These include possible failures of meta-cognition (thinking about thoughts) or an absence of flexibility in terms of interpretations. It might be difficult for those who have not been capable of these types of thought processes to discuss them. Need a further consultation with Tony on methodology re this point. Phillipa has suggested using some quantitative measures in addition to the qualitative stuff. I'm a bit reluctant about this however as it does seem to run counter to the rationale of generating material rather than anticipating what will come out.

May 28th

Tony doesn't seem to think the reflection business will be a problem. He was encouraging about the methodology. What he was implying was that if I'm going to do a grounded theory project its probably as well to be as open as possible to what I'm going to find. I need to meet with him again, after the proposal is in, to decide more clearly on the subject areas for the interview. I don't want to lead people too much.

20th Sept

Discussion with Philippa has suggested a modification to the methodology. In this case using clients and therapists from the same dyads. If I get therapists to suggest two clients each (someone who has done well and someone who has not done so well) then this may actually ease recruiting as well as affording reflections from different sides of the same dyad. Also tightened up the criteria for therapy, (both the length and the type). There is no course for CBT with psychosis so the selection criteria for therapists (and therapy conducted) will have to be based around self-identification as cognitive therapists, working within one of the standard models. There could be quite a bit of variability here so I'll need to try and be tight in the application of these criteria. We identified a number of potential therapists whom I will approach over the next few weeks.

Selection criteria for clients may also have some variability. It seems unlikely that all therapists will have used the same outcome measures. This criterion may be partly determined by who and what are available. We've decided that they should have had 12 sessions of therapy as this appears to be the point where improvement begins to level out.

Oct 6th

Interview schedule is looking somewhat clearer after psychosis seminar and also meeting with Len Rowland. The former really made me think about some of the broader issues for people with psychosis (jobs, housing etc). This ties in very well with the issues that Len raised about how "open" or "closed" questions are. It seems most important to keep the questions open towards the beginning of the interview as once you've become more specific its fairly difficult to go back. There are questions here relating to how much information I give participants before commencing. Some of the psychologists have asked to see information. They may have the expectation that I want to talk about the therapy so that is already set. For the clients I'd like to start our more broadly than this. The main question of the study is about the factors which may predict outcome of therapy. However these may be affected by a range of external factors (e.g. getting a job or whatever).

Nov 15th 1999

Interview schedule is looking fairly settled now following discussions with a number of colleagues and other psychologists who work with people with psychoses. It is particularly open at the beginning and then each question funnels into more specifics. I have decided to include a section specifically on therapeutic alliance probing three main dimensions of confidence, trust and sense of shared aim. Also have decided to ask people to describe techniques used in therapy as this may provide a point of similarity or contrast.

Jan 27th 2000

Ethics has been accepted by . However was slightly mislead about reciprocal arrangements and have to make separate applications to and . Of more concern is difficulty in getting "hard" outcome data. I think I have to relax this criteria for expediency as hardly anyone seems to have outcome questionnaire measures. It may be that its going to be a fairly pure comparison of perspectives and definitions of success and failure.

Feb 1st

Have completed pilot interviews with two fellow trainees as a dry run through the schedule. Seems clear, though they both suggested opening further and starting with "Tell me about your therapy?" as the first question as they described sense of expectation as questions became more specific.

Feb 25th

Have run three interviews with clients so far. The first was particularly difficult and lasted for less than 15 minutes. I felt extremely thrown by the client (who was defined as someone who had *progressed*) was exceedingly difficult to engage (in fact it felt impossible), had rapid indistinct speech, short answers and was extremely restless. It perhaps didn't help that I was introduced as "Dr.", something which I will avoid in future as it may be intimidating as it may set up unwanted expectations.

Initially felt that first interview was a disaster and I would have to see another client. It did seem more lucid while I was transcribing though and my own handling of it not nearly as bad as I thought initially. Felt somewhat better about the second and third interviews though engagement still a bit of a struggle with the client from the "non-progressor" group.

Mar 14th

Finally managed to interview first therapist. Some difficulties in using the interview schedule for discussion of two people at once. However I'll try and stick with this as I want to pick up discourse around contrast if at all possible. He also asked about his reactions to the client. I will ask each person this also to provide a comparison to my own reactions.

Proceeding with transcribing. I think one of the main revelations is just listening to some of the service users. Really listening I mean. Speech that under normal circumstances most people (I assume) just edit out or let their attention slide over. It comes as a shock at points to realise that I'm doing this to an extent as well and then, when you listen to a recording several times and work out what's being said, the communications are very salient and often very painful. Actually I'm quite surprised listening to the recordings by how much I am actually trying to listen but I realise that my first reaction is always to move one. A fairly grim insight into the world of some of the participants really.

May 7th

The recruiting is going better. Have now interviews 8 altogether. I think the projected 18 people is going to be 12 in the end. In terms of the depth of the analysis this would appear to give me a lot more scope and it is still eight therapeutic dyads. Trying to get the people in the threes required had made things much, much more difficult and the people who have not done so well have been rather more difficult to get to agree than those considered by therapists to have made progress.

The grounded theory rationale is beginning to make a lot more sense. I think that this is definitely the most appropriate method in the sense that I am trying to develop a theory (including testable hypotheses) and really let it be guided by the data it seems the best method to apply. It also seems that there is great scope for looking at context and meaning (implicit and more explicit). Initially it felt like a lot of this might get lost.

I've had a number of ideas re validity and the distinctness of this investigation from a controlled trial. First of all I think I have to accept that, while I have to establish that people are using cognitive therapy in a broad sense, it is clear that "real world" therapy is very different from the manualised therapy that is used in an RCT. I think this is just realistic really and not at all a bad thing. I can see much more clearly that therapy is all about individual understandings than packages of treatment for apparently homogeneous diagnostic categories. In the end there is no way of controlling the *internal* validity in the same way as a good RCT. This obviously does not mean I should abandon selection criteria but I do feel a lot more comfortable about the "messy" real therapies that I'm considering. The study seems to contribute something different which would not, as discussed before, be something which might come out of an RCT (which in any case

someone in my position does not have the resources to carry out). There is the analysis of meaning and a much higher external validity. The picture drawn by Roth and Fonagy of how research fits into clinical practice certainly envisages a role for this kind of work.

On a related point I made moves the other to start the lit review as a bit of relief from coding and analysis. However a number of the books counsel caution on this point and perhaps getting more analysis under my belt first. I think I have to give this a go. I've read a lot and already have a number of preconceptions. Actually setting up the lit review (though it would feel calming in terms of completion of the thesis) might not help in terms of being guided by the data: let myself be surprised. At present I'm not sure if the data is blindingly obvious or not. Philippa suggested that if it does look obvious (and sensible) then this is a good start. Better than it looking odd maybe.

May 31st

The micro coding (line by line coding) is producing interesting (and somewhat surprising) insights. In one interview I had been assuming that the particular client concerned had been describing an ability to engage with a cognitive frame and a process of weighing evidence. However, on further consideration, I realised that what she was actually saying involved a process of moving from a position where she felt she had to (but was unable to) make some kind of internal shift in her beliefs about her delusions to a position where she felt able to be guided by external evidence. This made a difference to her sense of distress though it was not the kind of shift she had been seeking. For other clients it appears to be a matter of external to internal shifts i.e. not locating hallucinations outside but inside instead. This lead to a notion of the importance of bridging between different types of experience. I haven't quite sorted this them out yet but I think it is potentially important.

The small(ish) sample that I'm using is actually allowing me to use microanalysis on all of the scripts. This may be useful as that data feel as if there is a great deal of variability and difference in experience. There is also the issue of looking at whether the emergent coding structures match and diverge for the two groups of clients relative to the therapists.

June 19th

Finished the last interview early in the month. This delay in the last few did enable a measure of theoretical sampling which I thought might not initially be possible. In particular amended the schedule to focus on checking out the emerging notion of bridging between different realities. Internal to external and vice versa. Final therapist I talked to particularly seemed to feel it had resonance for some of her more severe inpatient cases. Doesn't apply to everyone though. I think this construct needs a bit of refining. Particularly looking at instances which may falsify the theory.

One thing has also struck me from the difficulty of coding the "non-progressors". Two of the four do seem thought disordered in terms of their presentation. I realise definitions vary here but there is a lack of coherence and a difficulty in staying on one topic of conversation. This does seem to tie into the bridging into other realities. I realise after writing the lit. review that this is an area which appears neglected by the cognitive approach. The focus seems entirely on delusions and hallucinations. Another thing that comes out is the complete absence of holding of the session material among the "non-progressors". This ties right back to the beginning of the investigation and the fear that this

group would not be able to reflect on the process. Looking at the absences in discourse is revealing.

July 8th

The axial coding scheme is more or less complete. Tried to concentrate particularly on discriminant areas as there is a great deal of material. A number of lines which appeared as if they were going to discriminate petered out as were not supported. These included social skills, nature of beliefs (poor me vs. bad me delusions), and interpretation as illness or not. This last point was particularly interesting at it lead to what was, for me, perhaps the most important code. Members of the "non progressors" group had an illness model or other understanding that might be expected to preclude a psychotic understanding. Their illness model just happened to co-exist with a delusional belief system. Rather than bridging between realities, which I was looking for in the later scripts, the concept appears to be more one of inhibiting or ruling out psychotic ideas in order to be able to step forward logically. (i.e. shifting is leaving the old belief behind rather than just having a new one). If you still have both you can hop between them. This appears also to be implicated in the category on clarity of thinking about condition, or reflecting ability.

July 10th

A few final thoughts on the overall theme of the results: the "core" code. The five main discriminating categories emerging from the data, particularly "moving on", "clarity, "continuity", "remembering and understanding", "and shared goal" all appear to be part of a broader category connected with understanding and holding the therapist's reality. This is related to the extent that the client can engage with the reality provided by the therapist and move from their more psychotic reality. At first glance this seems to flesh out for me the kinds of ideas put forward by Chadwick and also Garety relating to reaction to hypothetical contradiction and "possibility of being mistaken" (from the MADS). Both of these notions seem to suggest an ability to move on into a new understanding and (more implicitly perhaps) moving on from distressing understandings. The results I have certainly seem to suggest that this kind of ability to engage with new understanding is central to progress in CBT terms. I think this theme has to be developed in the discussion.

The project does appear to answer a question "*what* is different about the therapies of those who progress and don't progress". The main theme provides the basis of an answer. However, there are also equally important questions of "*why* do they not progress" and "*how* can this be changed". I'm not really sure the project provides very much information to answer these questions. On the basis of what does appear in the interviews there is a suggestion that inability to move on may involve emotional investment in the psychotic belief system. (This comes only from one therapists account of one non-progressor). The other suggestion may involve more cognitive reasons to do with this kinds of models suggesting inappropriate assignment of meaning to irrelevant stimuli (e.g. Hemsley, Frith). This kind of reasoning is taken up in the discussion. The question of *how* may be one for another project.

Annotated Script from Interview with P1*

I = Interviewer

Focused Codes	Micro Codes	Client Participant P1
		I: Can you tell me about seeing T1 for therapy?
	Therapy helpful Enhanced understanding	P1: I like him and I think he's very helpful. He's helped me understand the voices more.
		I: He's helped you understand your voices more.
Enhanced understanding from therapy	Enhanced understanding	P1: Yeah.
		I: …What else can you tell me.
		P1: About him?
		I: About the therapy with him.
	Therapy helpful	P1: Very helpful innit.
		I: Could you give me some idea of the circumstances which led you to the therapy with T1?
	Voices tormenting Screaming in response	P1: I was getting tormented yeah. I keep screaming all the time, shouting, up stairs.
Describing torment of voices and effects		I: You were screaming?
	Occurring in room Screaming because of voices	P1: In my room, in my room yeah.
		I: And why were you screaming?
		P1: I was hearing these voices starting, starting voices again.
		I: Can you tell me a little bit more about the voices.
	Reporting content of voices	P1: They kept saying all the time "your having all the fun there's nothing for us" yeah. That's what they said yeah.
		I: "Your having all the fun there's nothing for us"
	Voices resenting him Voices all the time	P1: The kept resenting that I have all the fun that they don't have. They keep talking all the time "let us have fun too". Yeah.
Reporting content of voices	Voices demanding inclusion	I: So the idea that you were having fun but the voices weren't. Where were the voices coming from?
	Initially external locus Therapist involved in change/ Shift to internal locus	P1: I though they were coming from people in the world. But since T1's come just lately I think maybe its a trick of the mind more than telepathy. Also I thought it might be Satan but, Satan or telepathy. The original two explanations yeah.
	Thought Satan or telepathy in past	I: So it seemed originally they might be coming form outside like from Satan…
		P1: That's what I thought yeah.
	Thought Satan or telepathy	I: …but now you're thinking that…
Shifting from external to internal locus		P1: That is must be a trick of the mind like T1 said
	Trick of the mind/Internal source This therapists opinion	I: A trick of the mind.
		P1: That's what he thinks yeah.
		I: Is that helpful
	Accepting internal interpretation Medication getting rid of voices	P1: Yeah I think that's right yeah. I take medicine see and we think it acts as an agent for getting rid of the voices in the mind. Its worked, it seems to work they've gone down a lot. Since the medicine I'm taking yeah. Its respiridone the medicine.
Medication reducing voices	Medication reducing voices/ Effect of medication	I: Right, so it sounds like there's been two things going on. You've been taking a change in medication and you've seen

* All identifying information has been removed and any names quoted have been changed.

		T1 for sessions. Have both these things helped?
Two sources of help	Medication and therapy helping	P1: Both helped yeah.
	Voices difficult	I: Were the voices difficult for you?
		P1: Difficult yeah
	Expectation unclear	I: Right OK so from the sounds of it a while ago you started these sessions with T1. What did you expect?
	Couldn't understand	P1: I didn't know really. Had to answer a lot of questions I couldn't understand. I found it quite hard but I could understand it yeah.
	Understood against expectation	I: So you thought he might ask questions you didn't understand.
	Could understand	P1: Could understand him yeah. At first it was hard. At first it was. Long talks all the time yeah. About voices. I could understand it.
	Initially difficult	I: It sounds like you thought it was going to be a bit difficult to understand him at the start but after the beginning it was OK.
	Length of conversations	P1: Could understand him yeah.
	Could understand	I: What did you want when you came to see him?
Understood therapy against expectations		P1: They asked me if I'd like to see him. I said yes, I agreed to it.
	Could understand	I: What did you want from the sessions?
	Not clear what wanted	P1: I didn't ask for the sessions myself its just in a review a while ago they said "there's someone called T1 here, psychologist. Would you like to see him. He might be able to help with the voices".
	No clear wishes	I: Your saying they thought he might be able to help with the voices.
Expectations unclear	Instigated by others	P1: I agreed to it yeah. I didn't know what to expect really. It'd be hard I thought yeah cos I didn't know what it would be like
	Suggestion of help with voices	I: So you thought it would be hard, you didn't know what it would be like. but the way you understood it was that it was going to try and help you with the voices.
	No clear expectation	P1: Yeah voices tormenting me.
	Expected it to be difficult	I: What did you think that would be helpful with. Making the voices go away or would it be making them less tormenting?
Expectations unclear	No clear expectation	P1: …Both
		I: Both yes. So the idea of making the voices go away was in there.
	Torment of voices	P1: Ether really either
		I: Either?
	Unclear on expectation	P1: yeah.
	Unclear if voice elimination a goal	I: Well, was it what you expected.
Unclear on goal as reduced distress or elimination of voices		P1: It was good yeah. I'd go back yeah.
	Therapy good/Would have more	I: So was it in line with what you though therapy might be.
		P1: Yeah, yeah.
	Agree in line with expectation	I: Did you have any idea of what therapy was like before you.
	Therapy before	P1: Yeah, yeah I'd done therapy.
		I: Was therapy with T1 the way you expected it to be.
	No clear expectation	P1: As I say I didn't know what it would be like. But I found out what it was like talking to a psychologist. I never had a psychologist before T1.He introduced me to the voice
	Found out more	
	No psychologist before	

Remembering specifics	Remembering specifics	monitoring sheet.
		I: What was the Voice Monitoring Sheet.
	Remembering specifics	P1: Its a daily record of how the voices work how they're tormenting me yeah.
	Recording effects of voices	
		I: So you noted down things on the voice monitoring sheet.
	Recording	P1: Yeah
		I: How did that help.
	Partial description of how helpful/ Keeping track	P1: Helps it. It helps me keep a record of what the voices are saying so I know where I stand with the voices.
Recording effects of voices	Keeping track	I: So you're saying that was helpful. How you stand with the voices.
		P1: Keep a track of it yeah.
		I: You said something there that you seemed to have found helpful. The voice monitoring sheet. What other things did you find helpful?
Explanation of voices helpful	Explanation of voices helpful	P1: The explanation of the voices of T1 . The explanations. Yeah. First of all we talked about, we discussed and I said I think its either telepathy or Satan that causes the voices yeah. And we talk about that you see. And then by a process of con…con…, what is it? A process of elimination yeah. That was it
	First discussions	
	First explanations Satan and telepathy	
Eliminating earlier explanations	Talking about explanations/ Eliminating explanations	I: So you originally said it was either Satan or..
	Eliminating satanic explanation	P1: Satan yeah. I eliminated Satan.
		I: You eliminated Satan
	Changed interpretation to telepathy	P1: Eliminated Satan and said it was telepathy yeah.
	Internal interpretation	I: And said it was telepathy. And then what happened.
Changing interpretations helpful	Scientific interpretation	P1: And later on he said it was a trick of the mind and gave me a scientific explanation why that is.
		I: So you went through various possibilities for what the voices were and the notion of them as a trick of the mind was helpful.
	Internal interpretation helpful	P1: Helpful yeah.
		I: Was there anything else that was particularly helpful about the therapy.
	Nothing else helpful	P1: …Just that
		I: Just that. OK so there was the monitoring sheets and the explanations of the voices. Was there anything in the therapy that you didn't find so helpful.
	Whole thing helpful	P1: It all helped all of it all together
		I: OK, right you've mentioned what T1 was like. Can you tell me a little bit more about your relationship with him.
	Not understanding question	P1: Relationship? You mean?
		I: Just what it was like being with him and him coming to see you?
Open and honest relationship with therapist	Open and honest relationship/ Therapist told him he was	P1: …..Very open and honest it was. He said that I was open and honest T1 said.
		I: Did you feel the same?
	He feels open and honest	P1: Yes.
		I: So it was and open and honest relationship.
	Open and honest	P1: Yeah
		I: What about, did you feel that you could have confidence in
	Agreeing confidence present	P1: Confidence yeah.
		I: What about trust?
	Agreeing trust present	P1: Trust too yeah, trust too

Remebering specific suggestions	Requesting clarification	P1: The voice sheets? I: Mmmm P1: Suggestions? I: What kind of suggestion did T1 make.
	Remembering specific suggestions/ recording details/ Where, what who, when	P1: They said emh write down details of the day yeah? Where are you, what are you doing, who is with you yeah and also if my friend Bob was here and what time. What time he was here. That's right. Then there's another column, what level are the voices yeah? Then describe anything you did to make the voices less and did anything make the voice worse. That's the sheet yeah.
Description of suggestion	Description of sheet Rating voices Things that affect voices	
	Found sheet simple	I: And these columns about things that are making the voices worse or better was that easy to fill out. P1: Yeah simple that. I found it simple.
	Work helping fill out/ changing subject	I: What kind things made it easy P1: Work made it easy upstairs in my room downstairs and outside.
	Work distracting from voices	I: Work made it easy? P1: Helps with the voices yeah. Helps keep my mind off the voices
	Describing work	I: What kind of things made it better? P1: Cleaning, cooking, shopping, washing.
He finds work helps (distraction)	He finds work helps Since he has talked about them	I: So doing things made it better. Was that something that they suggested or was that something that you.. P1: Ever since I, ever since the voices got particularly bad about a year ever since I first started talking about them I'm found that the work has helped to me.
Explaining purpose of technique	Requestion clarification	I: Right, OK so from your point of view what was the point of giving you these things? P1: Sheets?
	Explaining purpose of sheets/ Purpose is also enjoyment	I: From your point of view what was the point of it. P1: Keep a track of it and for the enjoyment of it. Enjoyment of writing the sheet out.
Dismissing voices helpful/ Process becoming internal	Remembering suggestion Dismiss voices	I: Were there any other suggestions that they made? P1: To write down on the sheet? I: Well just in general. Can you think of anything else that they suggested. P1: They said "tell them to go away, don't let them rule you". "Don't let the over rule you". T1 said that yes. I: And was that helpful? P1: Yeah, I felt that it helped. I'd say "go away voices" I'd say.
	Dismissing helpful Internalising dismissal Self talk	I: And do you still do that? P1: I don't actually say it but I still try and over rule them get rid of them talk to them by self talk. And not loud.
Describing blocking methods/ Not working	Describing suggestions/ Blocking methods	I: Is there any other suggestions that they made P1: .....Take a radio down the street yeah and also try these ear plugs.
	Didn't try radio/ Ear-plugs didn't work	I: Were those helpful? P1: I didn't try the radio. I tried the ear plugs that didn't work and the radio I didn't fancy trying.
	Radio: hear music in street	I: So it was carrying a radio with you? P1: To hear music in the street.
	Didn't like suggestion	I: Earphones or something like that? P1: Yes I didn't fancy it.

		I: What kind of things were you able to trust him about.
Operationalising trust	Operationalising trust Trust to disclose/ Trust therapist not to betray/ trust not to disclose/ Not to say things to people Mutuality about disclosure	P1: Disclosing about the voices. Trust him not to do anything wrong with them. Tell people about it when I didn't want them too. I did tell him that I wanted to tell people in the office yeah. I did tell him that I wanted to. I agreed to it yeah.
	Other knew	I: Had people in the office in the office not known that you had had the..
Mutuality about disclosure	They were told (when it was OK?)	P1: They knew I have voices yes. I: The people in the office.. P1: Were told yeah
	He controlled disclosure	I: The people in the office were told, but before the therapy did they know.
	Long term voices/ Didn't disclose	P1: It was only when I first started do it that they knew. I: How long have you had the voices P1: I've had the voices for donkey's years but I didn't mention it.
	Mentioned only recently	I: It was only P1: It was only about a year or so ago I mentioned it yeah.
		I: Only a year or so.. right that must have been very difficult. P1: yeah
		I: Did you feel that yourself and T1 were working towards the same thing?
	Asking for clarification	P1: What do you mean the same thing?
	Agreeing same goal	I: The same goal really. P1: Same goal yeah
		I: What was the goal?
	Goal to get rid of voices	P1: To get rid of these voices. Completely if possible. Not just reduced but gone completely hopefully.
Goal reassessed	Only reduced/ Goal reassessed?	I: So they're reduced P1: Reduced but not all gone
	Voices not completely gone	I: They're reduced but not all gone completely. P1: Yeah
	Things changed	I: It sounds like things have changed quite a bit with the respiridone and the therapy as well. P1: Yeah
		I: You talked about it being open and honest. Were there any other things in your relationship that you found helpful with them.
	Clarity of therapy relationship	P1: It was very clear, very clear.
	Clear	I: Very clear? P1: Clear yeah
	Nothing else	I: Was there anything else about them that was helpful. P1: I can't think of anything else no.
	Nothing unhelpful/All good	I: Was there anything about it that was unhelpful? P1: No all good.
		I: You mentioned at the beginning that you were afraid that you wouldn't understand?
Understood therapy	Understood therapy	P1: I did understand yeah I: Right from the word go?
	Understood therapy	P1: I did yeah. I understood it.
		I: OK we've talked a little bit about what went on., talked about the sheets. What kind of suggestions did he make about using the sheets?

		I: You didn't try that. But the ear plugs didn't work?
Blocking not working	Earplugs not effective	P1: I tried the ear plugs yeah but they didn't do any good.
		I: OK was there anything else
	Nothing else	P1: I can't think of anything else no.
		I: OK how are you now?
Improvement from therapy and medication	Improvement from therapy and medication	P1: How am I? I'm a lot better from this therapy yeah and from the medicine. Physically I'm good yeah; get more exercise perhaps.
	Physically good/ Get more exercise	I: What about in your mind?
	Still voices/ Worrying that voices wrong/ Are voices wrong	P1: I've got these voices perhaps. Are the voices bad are they? Are they wrong or not? Is it wrong to have voices?
		I: I don't know?
Making own moral decision	Making own moral decision	P1: I think its not wrong. I say its not bad at the moment. So I say I'm alright.
		I: You say your alright
Absolving self from blame	Absolving self from blame	P1: The voices aren't my fault.
		I: So in your mind you're still having these voices. Are they still the same as they were before?
Voices reduced	Voices reduced	P1: They're less, less.
		I: And what about they way you deal with them, how's that?
		P1: I deal with them as well as I can yeah.
	Dealing with them	I: Has that changed?
	Medication helping	P1: Less, medicine, medicine yeah. Helps me, helps them to go away yeah.
Medication helping		I: You also said, I'm thinking of some of the suggestions that were in the therapy. Has the way that the way that you deal with the voices changed. When the voices come do you do anything different?
	More reasonable response	P1: Just the same but more reasonably. Probably the medicine, probably the medicine yeah. The went just after I started the medicine see. Went down, went down.
	Medication reduced voices	
		I: Since the therapy, do you anything different when the voices come.
	Changed response to voices/ Remembering specific suggestion	P1: I write the sheets, the sheets, I didn't do that before.
Changed response to voices		I: And is that change because of the therapy.
	No sheets before therapy	P1: The sheets? I didn't do the sheets at all before. Before the therapy
		I: And is that a helpful change?
	Change helpful	P1: Yes, helpful. I'm going to go on with it. Go on with the sheets.
		I: Have you got anything else you'd like to say about this while we're talking about it
	Nothing to add	P1: No I can't think of anything else unless you can think of anything.
		I: I'm just looking down my list of questions and seeing if theres anything else. I don't think there is. You'd say the main' things, the main changes were the sheets, the understanding of the voices.
		P1: Yeah.
		I: Maybe one more little thing about the understanding of the voices. You said you understand them in a different way now. When the voices come does that change things. The fact that you've got a different idea of what they mean.

Reduced distress from new interpretation	Requesting clarification	P1: They change? I: That fact that when the voices come you seem to be thinking about them in a different way. what difference does that make to you?
	Reduced distress from new interpretation	P1: .....I prefer the new explanation yeah. I: You prefer the new explanation. Is the new explanation less frightening.
	Reduced distress from new interpretation	P1: Less frightening yeah. Than Satan. Satan's the Devil isn't he. A trick of the mind doesn't seem so frightening does it.
	Voices easier from new interpretation	I: Does that make the voices easier. P1: Yeah
	Internal explanation better	I: And the idea of them being a trick of the mind, was that something that was hard to take on board? P1: Its better, better.

Inter-Rater Reliability Study

Task 1

In this study you will be given the descriptions of six categories. You will use these in Task 1. You have been given a list of given a list of 15 quotations. For each quotation I would like you to signal the category to which you think the quotation belongs from the list below. Please ask if you require further description of the categories.

(i) Definitions of progress

In this category there are a number of quotations from therapists suggesting that clients *did or did not* progress or benefit in therapy. There are also quotations from clients who have received therapy.

(ii) Being able to move clearly to new interpretations while disregarding old

Again there are therapist and client quotations. In this case signalling a new understanding while moving on from an old understanding.

(iii) Ability to think reflectively or logically

This code refers to therapist discourse on the importance of the clarity and logic of clients thinking in making progress in therapy. The views of therapists are supported by illustrations of clear and unclear thinking in client discourse.

(iv) Continuity in therapy

This code described therapist's discourse concerning the ability of clients to work on therapy with a measure of continuity from session to session.

(v) Remembering and understanding therapy

These quotations are intended the ability or willingness of clients to describe elements of their therapeutic work after therapy was complete.

(vi) Shared goal

Quotations are intended to reflect the presence of a shared goal or otherwise between therapist and client in therapy.

Tasks 2 and 3

For each category heading you have now been presented with a set of quotations which in the opinion of the researcher are illustrative of the particular category concerned. These quotations are provided on the attached yellow sheets. I have classified the sets of quotations from each category into two *sub-categories* each and then the quotes from each sub-category into a number of *sub-dimensions*. There are thus three levels of classification all together. What I would like you do is to is to classify the quotations for each main category using the sub-categories and sub-dimensions that I developed for them you are provided with lists of these sub-categories and sub-dimensions. There are two classification tasks.

Task 2

In this task you are asked to classify the quotations in each set into sub-categories. Use the signifier accompanying the sub-category. Please be guided by the main category definitions on the previous page.

(i) Definitions of progress- *Quotation set 1*

Please sort the quotations into two sub categories:

A. Quotations which suggest that the client has progressed or failed to progress in cognitive behavioural therapy terms.
B. Quotations which suggest the client has benefited or failed to benefit in more general terms.

Please mark your classification of each quotation in the column headed Task 2.

(ii) Being able to move clearly to new interpretations while disregarding old-*Quotation Set 2*

Once again I would like you to sort the quotations into two sub-categories:

A. Quotations suggesting ability to move on from distressing understandings
B. Quotations suggesting inability to move on from distressing understanding

(iii) Ability to think reflectively or logically *-Quotation Set 3*

Once again I would like you to sort the quotations into two sub-categories:

A. Ability to think clearly and reflectively in therapy
B. Inability to think clearly and reflectively in therapy

(iv) Continuity in therapy *-Quotation Set 4*

Once again I would like you to sort the quotations into two sub-categories:

A. Continuity in therapy
B. Absence of continuity

(v) Remembering and understanding therapy-*Quotation Set 5*

Once again I would like you to sort the quotations into two sub-categories:

A. Clear memory and understanding of therapy
B. Less clear memory and understanding of therapy

(vi) Shared goal *-Quotation Set 6*

Once again I would like you to sort the quotations into two sub-categories:

A. Shared goal clearly observable
B. Shared task not present

Task 3

In this task you are given the answers to the last task in the right hand margin. Now what I would like you to do is classify the statements *from each sub-category* according to a more extensive list of *sub dimensions*. Use the numerical signifier accompanying the sub dimension.

(i) Definitions of progress - *Quotation set 1*
In this task firstly I would like you to sort the *sub-category A* quotations into seven further sub-dimensions:

1. Changed interpretation of symptoms
2. Changed means of dealing with symptoms
3. Reduced distress relative to symptom(s)
4. Managing mood variations
5. Practical improvements
6. No changes interpretation of symptoms
7. Therapist does not feel there is an improvement

Secondly I would like you to sort the quotations signalled as being in *sub-category B* into the following sub-dimensions.

11. Usefulness of turning up
12. Usefulness of experiences being taken seriously
13. Helping to discuss difficult environment
14. Usefulness of continued engagement
15. Seeing others as real and permanent
16. Providing social contact
17. Importance of talking/being listened to

Please signal your response in the Task 3 column.

(ii) Being able to move clearly to new interpretations while disregarding old -*Quotation Set 2*
In this task I want you to sort the quotations into from sub category A into the following sub-dimensions:

1. Explanation being eliminated by logical challenge
2. One explanation superseding another
3. Understanding inhibiting psychotic experience
4. One explanation ruling out two others
5. Eliminating other explanations
6. Use of external evidence to disprove psychotic thoughts
7. Putting boundaries round other explanations

Then sort the *sub-category B* quotations into the following sub-dimensions:

11. Holding two explanations simultaneously
12. Sliding into other multiple explanations
13. New knowledge failing to eliminate earlier interpretation
14. Contrasting statements during interview
15. In vivo alternative realities
16. No control over engaging with psychotic thoughts

(iii) Ability to think reflectively or logically *-Quotation Set 3*
Please sort the *sub-category A* quotes into the following sub-dimensions:
1. Using the therapist to aid clarity of thought
2. Clear thinking aiding understanding
3. Thinking about thinking affording the possibility of change

Then please sort the *sub-category B* quotes into the following dimensions.
11. Inability to think clearly enough
12. Inability to think logically enough

(iv) Continuity in therapy *-Quotation Set 4*
Please sort the *sub-category B only* quotations into the following sub-dimensions
1. Absence of continuity
2. Discontinuity in client's experiential world

(v) Remembering and understanding therapy-*Quotation Set 5*
Please sort the *sub-category A* quotations into the following sub-dimensions
1. Remembering a specific suggestion
2. Operationalising a change

Then sort the *sub-category B* quotations into the following two sub-dimensions
11. Failing to remember specific suggestions
12. Failing to operationalise the idea of helpful

(vi) Shared goal *-Quotation Set 6*
Please sort the *sub-category B only* quotations into the following sub-dimensions
1. No sense of shared task
2. Impossibility of sharing task with client
3. All therapy tasks not being shared
4. Client has different agenda
5. Therapist becoming incorporated into the delusional system of client

Kappa analyses tables

Task 1: Quotes into main categories.

		Value	Asymp. Std. Error(a)	Approx. T(b)	Approx. Sig.
Measure of Agreement	Kappa	.676	.140	5.750	.000
N of Valid Cases		15			

Task 2: Category 1 quotations classified according to sub-categories.

		Value	Asymp. Std. Error(a)	Approx. T(b)	Approx. Sig.
Measure of Agreement	Kappa	.714	.179	2.789	.005
N of Valid Cases		14			

Task 2: Category 2 quotations classified according to sub-categories.

		Value	Asymp. Std. Error(a)	Approx. T(b)	Approx. Sig.
Measure of Agreement	Kappa	1.000	.000	4.359	.000
N of Valid Cases		19			

Task 2: Category 3 quotations classified according to sub-categories.

		Value	Asymp. Std. Error(a)	Approx. T(b)	Approx. Sig.
Measure of Agreement	Kappa	.720	.249	1.984	.047
N of Valid Cases		7			

Task 2: Category 4 quotations classified according to sub-categories.

		Value	Asymp. Std. Error(a)	Approx. T(b)	Approx. Sig.
Measure of Agreement	Kappa	1.000	.000	2.449	.014
N of Valid Cases		6			

Task 2: Category 5 quotations classified according to sub-categories.

		Value	Asymp. Std. Error(a)	Approx. T(b)	Approx. Sig.
Measure of Agreement	Kappa	1.000	.000	2.646	.008
N of Valid Cases		7			

Task 2: Category 6 quotations classified according to sub-categories.

		Value	Asymp. Std. Error(a)	Approx. T(b)	Approx. Sig.
Measure of Agreement	Kappa	.696	.268	1.932	.053
N of Valid Cases		7			

Task 3: Category 1 quotations classified according to sub-dimensions.

		Value	Asymp. Std. Error(a)	Approx. T(b)	Approx. Sig.
Measure of Agreement	Kappa	.852	.097	10.225	.000
N of Valid Cases		15			

Task 3: Category 2 quotations classified according to sub-dimensions.

		Value	Asymp. Std. Error(a)	Approx. T(b)	Approx. Sig.
Measure of Agreement	Kappa	.669	.111	9.647	.000
N of Valid Cases		20			

Task 3: Category 3 quotations classified according to sub-dimensions.

		Value	Asymp. Std. Error(a)	Approx. T(b)	Approx. Sig.
Measure of Agreement	Kappa	1.000	.000	5.065	.000
N of Valid Cases		7			

Task 3: Category 4 quotations classified according to sub-dimensions.

		Value	Asymp. Std. Error(a)	Approx. T(b)	Approx. Sig.
Measure of Agreement	Kappa	1.000	.000	1.732	.083
N of Valid Cases		3			

Task 3: Category 5 quotations classified according to sub-dimensions.

		Value	Asymp. Std. Error(a)	Approx. T(b)	Approx. Sig.
Measure of Agreement	Kappa	1.000	.000	4.279	.000
N of Valid Cases		7			

Task 3: Category 6 quotations classified according to sub-dimensions.

		Value	Asymp. Std. Error(a)	Approx. T(b)	Approx. Sig.
Measure of Agreement	Kappa	1.000	.000	3.770	.000
N of Valid Cases		5			

Respondent Validity Study

Overview

The main goal of this study was to establish how plausible the respondents felt the coding scheme to be. The therapist was asked to answer from general experience of working with psychosis. The clients were asked to answer from their own experience. The therapist (T2) was provided with main sub-categories from the coding scheme and asked to rate level of agreement with sub-categories as distinguishing between progressors and non-progressors in CBT for psychosis. Comments on the categories were also recorded. The procedure was altered slightly for the two clients in the study as a result of other considerations (outlined below).

Special considerations applying to clients

The open and comprehensive way the results were presented to the therapist in this study was considered potentially problematic for the two clients concerned (P3 and NP3). There were several reasons for this. Firstly, the two clients were not necessarily in a position to reflect on the position for progressors and non progressors. Secondly, it was obviously unethical to suggest these labels to the clients who after all were not self-identified. Thirdly, create possible difficulties for clients to share concepts such as "inability to think clearly" or "lack of shared goal". This applied particularly to the client from the NP group who may have been distressed by such concepts apparently applying to him. Fourthly, as both these clients were still in therapy the sharing of any such concepts might also create difficulties for further therapeutic engagement. Clearly therefore, a completely open sharing of the results of the study was impossible with the client group.

To establish more clearly how to proceed the author discussed these points with T3 (the therapist of the two clients concerned) before outlining a plan of the best way to present the results to the clients. The clients were presented with the themes pertaining to their own group where deemed suitable and they were asked to rate how much it applied to them. As P3 clearly felt that therapy had been of some benefit to her there appeared to be greater freedom to explore some of the ideas arising from the results with her. With NP3 on the other hand it was felt that the questioning had to be somewhat more circumspect. Therefore the two different interview schedules were drawn up for these two individuals.

All ratings were on a five point Likert scale ranging from "strongly disagree" (1) to strongly agree" (5).

Interview Schedules

Interview schedule and recording sheet for T2.
Questions framed around agreement with the categories as *distinguishing* between the two groups.

	Agreement score
Definitions of success	
You can define progress or failure to progress in CBT terms or more general terms?	5
Changed interpretations are a central component of CBT improvement?	5
Comments:	
Being able to move clearly to new interpretations while disregarding distressing interpretations	
Ability to move on from distressing understandings characterised those who progress compared to those who don't progress in CBT?	5
Comments:	
"Some people's thinking is quite confused. CBT doesn't really add to that. It doesn't provide a way to help them move on."	
Ability to think reflectively	
Ability to think reflectively in therapy distinguishes those who progress from those who don't?	4
Comments:	
"I think it probably does distinguish them but it may not be apparent at the beginning that some people's thought can become clear enough to engage properly."	
Continuity in therapy	
Continuity in therapy is an important distinguishing factor?	5
Comments:	
Remembering and understanding therapy	
Remembering and understanding therapy is a feature which distinguishes progressors and non-progressors?	5
Comments:	
Shared goal	
Shared goal distinguishes between progressors and non-progressors?	4
Comments:	
"Agendas evolve. The shared goal might distinguish people more at the end of therapy."	

Interview schedule and recording sheet for P2.

Questions are framed around asking P2 to extent of agreement with categories that appeared to characterise the P group.

	Agreement score
Definitions of success	
Changed understandings are important?	5
Being listened to and heard is important?	5

Comments:
"Both of these are extremely important."

Being able to move clearly to new interpretations while disregarding distressing interpretations	
Being able to move on from distressing ideas is important?	5

Comments:
"I got caught up in a old ground that was going nowhere. Being able to leave that behind was a major step for me."

Ability to think reflectively	
Ability to think and reflect in therapy important to you?	4

Comments:
"I just needed to find a place for the delusions."

Continuity in therapy	
Being able to hold themes over the weeks is important?	4

Comments:
"Yes, though I tend to give responsibility for that over to my therapist."

Description of specific elements in therapy	
Memories and understandings are clear?	4

Comments:
"I do have it in this therapy. It hasn't happened in other therapies I've had."

Shared goal	
Shared goal important?	5

Comments:
"Absolutely"

Interview schedule and recording sheet for NP2.

Questions are framed around the aspects of categories that appeared to characterise the NP group.

	Agreement score
Definitions of success	
Changed understandings are important?	5
Being listened to and heard is important?	5
Comments:	
"She has go me to change my understanding. Now I don't think my illness is a serious as I once did. Its not the end of the world any more."	
Being able to move clearly to new interpretations while disregarding distressing interpretations	
Moving on from distressing understandings is difficult?	5
Comments:	
"Yes that's important. Sometimes its just to difficult to stop them and I end up in my room having these thoughts."	
Ability to think reflectively	
Thinking clearly is important?	4
Comments:- I'm not sure he follows this question.	
Continuity in therapy	
Being able to hold themes over the weeks is important?	4
Comments:	
"Sometimes we'll change what we're talking about but its mainly the therapist who does that not me. I think that is important to me."	
Description of specific elements in therapy	
Clear memory of the therapy is that difficult?	4
Comments:	
"Its often difficult to remember."	
Shared goal	
Shared goal important?	5
Comments:	
"Its very important to me that she looks at what's important for me."	